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IN THE

Supreme Court of the United States

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v.

Russell E. Adkins, M.D.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether federal courts should recognize an evidentiary privilege against compelled disclosure of confidential, internal medical peer review communications under Rule 501 of the Federal Rules of Evidence.

RULE 29.6

Petitioner Hospital Authority of Houston County d/b/a Houston Medical Center does not have a parent corporation, and no publicly held company owns 10% or more of its stock.

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OPINIONS BELOW

The district court's unpublished order recognizing a medical peer review privilege against compelled disclosure of confidential medical peer review communications can be found at 2004 U.S. Dist. LEXIS 23010 (M.D. Ga. Nov. 10, 2004). (Pet. App. 16a-21a). The district court's unpublished order granting Petitioners' motion for summary judgment can be found at 2006 U.S. Dist. LEXIS 25668 (M.D. Ga. May 2, 2006). (Pet. App. 22a-47a). The Eleventh Circuit's opinion declining to recognize a medical peer review privilege and reversing the district court's order granting Petitioners' motion for summary judgment is reported at 488 F.3d 1324 (11th Cir. 2007). (Pet. App. 1a-15a). The Eleventh Circuit's unpublished order denying Petitioners' petition for rehearing *en banc* is reproduced in the Appendix hereto. (Pet. App. 48a-49a).

JURISDICTION

The Eleventh Circuit denied Petitioners' petition for rehearing *en banc* on August 16, 2007. (Pet. App. 48a-49a). This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

RELEVANT PROVISIONS INVOLVED

FED. R. EVID. 501:

> Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority,

> the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law.

STATEMENT

This case presents the question of whether federal courts should recognize an evidentiary privilege against compelled disclosure of confidential, internal medical peer review communications under Rule 501 of the Federal Rules of Evidence.

All fifty states and the District of Columbia have recognized a medical peer review privilege. The states strongly believe that a hospital's internal peer review process promotes public health and safety by ensuring quality patient care and fosters vital standards of care and treatment in hospitals. All states recognize that confidentiality is essential to the successful functioning of medical peer review and that compelled disclosure in litigation would eviscerate the public health benefits provided by medical peer review.

The Eleventh Circuit below added its voice to the growing disarray in the lower courts over how to reconcile this Court's decision in *University of Pennsylvania v. EEOC*, 493 U.S. 182 (1990) with its decision in *Jaffee v. Redmond*, 518 U.S. 1 (1996). This

Court in *University of Pennsylvania* declined to recognize a privilege for academic peer review of tenure decisions on the ground that such privilege "has no . . . historical or statutory basis," *id.* at 195, and appeared to weigh the value of the confidentiality against the value of disclosure in a particular case. The Court in *Jaffee*, in contrast, recognized a psychotherapist-patient privilege despite a lack of common law history or statutory guidance on the ground that such a privilege was essential for confidence and trust, served important public ends and was consistent with state rules. Furthermore, in apparent conflict with *University of Pennsylvania*, the Court in *Jaffee* expressly rejected weighing the value of confidentiality against the value of disclosure in a particular case.

The Eleventh Circuit's decision squarely contradicts *Jaffee*, presents a conflict in approach with the Fifth Circuit's decision in *United States v. Harris Methodist Ft. Worth*, 970 F.2d 94 (5th Cir. 1992), and further adds to the significant confusion in the lower courts over whether federal courts should follow the states and recognize a medical peer review privilege in light of *University of Pennsylvania* and *Jaffee*. Moreover, the Eleventh Circuit's decision ensures an intractable division between federal and state courts on an important issue of health and safety. Only this Court can reconcile its two decisions, and this case presents an excellent vehicle to provide guidance on this important issue.

A. The Importance Of Medical Peer Review

1. *Effective Peer Review Is Essential To Quality Health Care*

Medical peer review is the process by which physician members of a hospital's medical staff review medical errors of other members of the medical staff and by the hospital as a whole, evaluate the qualifications of applicants for new privileges or for renewal of privileges, and effect disciplinary actions against medical staff members. *See* Christopher S. Morter, Note, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting*, 74 VA. L. REV. 1115, 1117 (1988).

Peer review is essential to the quality of healthcare in this country. According to an April 2006 study, 250,246 potentially preventable deaths occurred in this country between 2002 and 2004, making medical errors "a leading cause of death in the U.S." *See HealthGrades Quality Study: 3rd Annual Patient Safety in American Hospitals Study* at 2, 4 (Apr. 2006), at www.healthgrades.com/media/dms/pdf/PatientSafetyInAmericanHospitalsStudy2006.pdf.

As the courts and commentators have observed, peer review enhances the quality of patient care through effective supervision of healthcare professionals, elimination from the healthcare system of those who should not practice, and treatment of those whose abilities are impaired and in need of rehabilitation. *See, e.g., Nilavar v. Mercy Health Sys.*, 210 F.R.D. 597, 600 (S.D. Ohio 2002) (peer review process "helps root out incompetence in the medical profession, which, in turn, leads to a higher overall level

of healthcare for patients. In addition, patients' awareness of this practice fosters a level of reassurance that they are receiving proper care"); Daniel Mulholland, III & Phil Zarone, *Waiver of the Peer Review Privilege, A Survey of the Law*, 49 S.D. L. REV. 424, 424 (2003/2004) ("[T]he hospital peer review system is the only meaningful, ongoing process by which medical care is monitored and evaluated and inferior care is dealt with through sanctions that prevent substandard practitioners from causing harm to patients."). As such, the work of medical peer review committees has been described as "life saving." *Weekoty v. United States*, 30 F. Supp. 2d 1343, 1344 (D.N.M. 1998).

The universal acceptance of peer review as the means by which a hospital and its medical staff scrutinize a physician's credentials and monitor the quality of care that is provided is reflected both in state law granting immunity to medical review participants and protecting the confidentiality of medical review proceedings, see, e.g., O.C.G.A. §§ 31-7-133 (2007), 31-7-143 (2007), and in the standards for hospital accreditation published by the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO"). JCAHO, the leading hospital accreditation body in the United States, requires medical staff committees to participate in efforts to measure outcomes and processes and to evaluate "individuals with clinical privileges whose performance is questioned as a result of the measurement and assessment activities." JCAHO, 2000 Hospital Accreditation Standards 303 (2000). The policy underlying the JCAHO standards is "to improve the quality of care provided to the public." Id. at ii. Similarly, the policy underlying state statutes protecting peer review activities is to "foster the

delivery of quality medical services." *See, e.g., Patton v. St. Francis Hosp.*, 539 S.E.2d 526, 528 (Ga. App. 2000).

2. Effective Peer Review Requires Confidentiality

Medical peer review can only be effective where the physicians engaged in the reviewing activities are able to maintain a frank, candid exchange of ideas. Full and fair evaluation of the quality of care of either an individual physician or an institution requires that the reviewing physicians be freely able to discuss and to criticize, if necessary, the actions taken by their colleagues. If committee members fail to engage in a candid evaluation of their fellow physicians' qualifications and actions, poor quality care will go uncorrected, and incompetent or impaired physicians will be allowed to continue practicing.

For this reason, every state and the District of Columbia has balanced the important interest in allowing litigants access to evidence against the enormous health and safety benefits of keeping medical peer review information confidential and has concluded that the balance favors recognizing a privilege for medical peer review. (Pet. App. 6a); Weekoty, 30 F. Supp. 2d at 1346-47 ("noting "at least forty-six states [and the District of Columbia] now have statutes that protect the work of medical peer review committees . . . from discovery or introduction as evidence at trial" and citing state statutes and sources listing state statutes) (internal citations and quotations omitted). These protections take a variety of forms, and arise both from statutes and from judicial decisions, but all protect the sanctity of medical peer review proceedings.

For example, Georgia's peer review privilege applies in "any civil action," including those actions where a physician is challenging the peer review process itself. *See Patton*, 539 S.E.2d at 529-30. Similarly, Idaho's statute states that "all peer review records shall be confidential and privileged, and shall not be directly or indirectly subject to subpoena or discovery proceedings or be admitted as evidence, nor shall testimony relating thereto be admitted in evidence, or in any action of any kind in any court or before any administrative body, agency or person for any purpose whatsoever." Idaho Code § 39-1392b (2007). Some states, such as Georgia and Michigan, protect peer review information even when it is disclosed to certain third parties – the sort of disclosure that can defeat less robust evidentiary privileges. *See Emory Clinic v. Houston*, 369 S.E.2d 913, 914 (Ga. 1988); Mich. Code § 333.2632 (2007).

State courts and legislatures recognize several vital public policies behind the enactment of these statutes. For example, Georgia's peer review statute reflects the "legislature's intent to foster the delivery of quality medical services by protecting the confidentiality of peer review records and preserving the candor necessary for the effective functioning of hospital medical review committees." *Patton*, 539 S.E.2d at 528. Idaho's legislature found that protecting peer review is important "for the purposes of reducing morbidity and mortality, [and] enforcing and improving the standards of medical practice in the state of Idaho." Idaho Code § 39-1392 (2007). The Minnesota Supreme Court has explained that "[t]hese statutes, and similar statutes in many other states, are designed to serve the strong public interest in improving the quality of health care." *Kalish v. Mount Sinai Hospital*, 270 N.W.2d

783, 785 (Minn. 1978). With respect to its peer review privilege, the Virginia Supreme Court observed "[t]he obvious legislative intent is to promote open and frank discussions during the peer review process among health care providers in furtherance of the overall goal of improvement of the health care system. If peer review information were not confidential, there would be little incentive to participate in the process." *HCA Health Servs. of Va. v. Levin*, 530 S.E.2d 417, 420 (Va. 2000). Finally, in surveying the legislative history of its state's law, the North Dakota Supreme Court found that "concerns were expressed that physicians would be unwilling to serve on quality assurance committees, and would not feel free to openly discuss the performance of other doctors practicing in the hospital, without assurance that their discussions in committee would be confidential and privileged. It was this purpose to encourage frank and open physician participation, and the resulting improvement in patient care, which underlies the privilege." *Trinity Medical Ctr. v. Holum*, 544 N.W.2d 148, 155 (N.D. 1996).

The Eleventh Circuit's decision allowing a plaintiff unfettered access to each and every peer review file at a hospital contradicts the states' recognition of the medical peer review privilege and has adverse consequences far beyond the parties before this Court. Such a decision weakens the peer process at every hospital, making physicians unwilling to participate in the vital peer review activity of eliminating mistakes or incompetence among doctors for fear that their participation will lead to litigation against themselves or their professional colleagues. A weakened system of self-regulation among the physician community puts at risk the lives of thousands of individual patients who rely each year on hospitals

and their medical staffs for life-saving treatment and care.

Notably, the harm suffered by the evisceration of the medical peer review privilege is not an abstract theory. Indeed, Petitioners produced evidence in this case demonstrating that upon the required disclosure of peer review information in *Marshall v. Americus-Sumter County Hosp. Auth.*, 2002 U.S. Dist. LEXIS 26822 (M.D. Ga. Nov. 22, 2002), a similar case brought by the same plaintiff's counsel who initially brought this case, physicians in Americus dramatically limited their participation in the peer review process and resigned from various hospital peer review functions. (R1-61-Ex. A at ¶ 6). The Eleventh Circuit's decision opens the door to this result occurring at every hospital and, as such, places patient care at risk.

B. Proceedings Below

Petitioners are the Houston Medical Center ("Hospital"); fourteen members of the Hospital's Medical Executive Committee ("MEC"), a peer review organization within the Hospital responsible for making recommendations regarding staff appointments and re-appointments, clinical privileges, and corrective action; and two members of the Hospital's administration (collectively referred to as "Healthcare Professionals").[1] Respondent Dr. Russell E. Adkins is an African-American physician specializing in the area of urology

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[1] Along with Petitioners, Plaintiff also sued an additional member of the MEC and ten professional practice groups which were allegedly owned and/or operated by certain of the Individual Defendants. These defendants were ultimately dismissed by Plaintiff. (R3-72-1; R3-75-1; R6-140-1; R7-144-1).

who formerly held privileges at the Hospital. (R1-1-¶ 2).

This suit arises out of the Hospital's decision to summarily suspend and later terminate Dr. Adkins' privileges following a series of issues concerning Dr. Adkins' professional judgment, care and treatment of two specific patients, availability, pre-admissions for surgery, completion of medical records, and attendance at meetings. (R7-149-Ex. B.8).

Dr. Adkins, in turn, sued the Healthcare Professionals under 42 U.S.C. §§ 1981, 1983, and 1985, alleging the decision to suspend and terminate his privileges was based on his race. (R1-1-¶¶ 2-3, 36).

After filing suit, Dr. Adkins served extensive discovery requests upon certain of the Healthcare Professionals, launching an attack at the heart of the medical peer review system – a system specifically designed to promote the health and safety of all patients. Specifically, Dr. Adkins' discovery requests, which totaled more than 1,100 interrogatories, including subparts, (R2-57-2 n.1; R2-57-Exs. G-K),[2]

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[2] Dr. Adkins was repeatedly warned throughout this action concerning the improper "fishing expedition" in which he appeared to be engaged. For example, in an October 20, 2004 Order, the district court noted, "It . . . appears that plaintiff's discovery request regarding peer review documents pertaining to other physicians is an overly broad fishing expedition to develop facts that *may* support a discrimination claim. This is prohibited by the Federal Rules of Civil Procedure." (R3-80-1) (emphasis in original).

Similarly, in a March 4, 2005 Order, the district court stated:

> The Court has instructed the [P]laintiff on numerous occasions . . . that his discovery requests evidence an intent

sought information on confidential peer review investigations and proceedings taking place on each and every physician at the Hospital since 1990.[3] (R2-57-Ex. G No. 13; R2-57-Ex. B Nos. 6, 10).

In view of the nature of Dr. Adkins' discovery requests, certain of the Healthcare Professionals moved for a protective order. (R2-56-1; R2-57-2). Specifically,

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> to develop facts that *may* support a discrimination claim. It has become clear that plaintiff is not aware of any other similarly situated physicians at Houston Medical Center who engaged in similar or worse misconduct but were not disciplined or terminated. Rather, the [P]laintiff appears to be using the discovery process to determine if there *may* have been other physicians who fell into this category and if he *may* have been discriminatorily suspended. These are impermissible discovery objectives, particularly when qualified immunity is applicable.

(R5-103-3) (emphasis in original).

Moreover, Dr. Adkins' own representations during the course of this litigation demonstrate his impermissible "fishing expedition." For example, in one pleading filed on his behalf in the district court, he stated, "Without first having the defendants' motion for summary judgment, and without first having the information requested in Plaintiff's motion to compel, Plaintiff is unable to articulate a discovery plan that will enable him to respond to the defendants' anticipated motion for summary judgment." (R4-101-5). Moreover, Dr. Adkins acknowledged at his deposition that he could not identify the name of any physician that was not African-American whom he believed was treated differently under similar circumstances. (R6-133-Defs' Ex. 2 at 56-57).

[3] Contrary to the Eleventh Circuit's suggestion, Dr. Adkins' peer review discovery requests were not limited to "the seven years that [Plaintiff] was a member of the hospital staff." (Pet. App. at 5a).

these Healthcare Professionals argued that, in light of this Court's decision in *Jaffee*, the states' unanimous recognition of the medical peer review privilege, and the health and safety interests furthered by the privilege, the privilege should be recognized to protect against disclosure of confidential medical peer review information pursuant to Rule 501 of the Federal Rules of Evidence, which governs when a privilege should be recognized in federal courts. (R2-57-1-19; R2-61-1-8; R3-65-1-5; R3-77-1-5). As pertinent here, Rule 501 authorizes federal courts to define new privileges in federal question cases by interpreting "principles of the common law . . . in the light of reason and experience."[4] FED. R. EVID. 501.

Following briefing and a hearing, which included participation by the Georgia Hospital Association and the Medical Association of Georgia as *amicus* in support of the Healthcare Professionals' position, the district court granted the motion for protective order. (Pet. App. 16a-21a).

In so doing, the district court recognized the "peer review process . . . serves as an integral part of the hospital's fulfillment of its duty to provide the best health care available and to ensure that any physicians who, for whatever reason, are not performing up to the hospital's expectations are subjected to a suspension of their hospital privileges." (Pet. App. 19a). The district court concluded that recognition of the medical peer review privilege is warranted under *Jaffee*, as the public's interest in promoting healthcare is served by

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[4] With respect to state law claims asserted in federal court, Rule 501 provides the applicability of a privilege "shall be determined in accordance with [s]tate law." FED. R. EVID. 501.

protecting confidential peer review information from disclosure and a consensus exists amongst the states for recognition of the privilege. (Pet. App. 19a-20a). The district court further noted that "little or no evidentiary benefit . . . . would result from the denial of the privilege in this case because the information the plaintiff seeks may very well be obtained from other sources such as through depositions of hospital administrators regarding general information about the hospital's policies and procedures for the peer review process and whether other individuals have been subjected to the same."[5] (Pet. App. 20a).

After the close of discovery,[6] the Health Care Professionals filed a motion for summary judgment, which the district court granted on May 2, 2006. (Pet. App. 22a-46a). Dr. Adkins appealed this decision, (R16-235-1), and the Eleventh Circuit reversed, declining to recognize a medical peer review privilege in "federal civil rights" or "federal discrimination cases" and concluding the "district court improperly limited the scope of discovery and, as a result, prematurely granted Defendants' motion for summary judgment." (Pet. App. 3a).

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[5] Notably, Dr. Adkins never took any of the depositions suggested by the district court.

[6] Although the district court initially determined that Dr. Adkins was precluded from any peer review discovery, it later ordered that Dr. Adkins be provided peer review information concerning himself and members of the Hospital's Department of Surgery (the department in which Dr. Adkins practiced) for the five years preceding the termination of Dr. Adkins' privileges, in the form of descriptions but not the peer review documents themselves. (R5-103-4-10; R5-109-2, 6). This information was produced to Dr. Adkins. (R7-185-1).

In reaching its decision, the Eleventh Circuit acknowledged the medical peer review privilege "serve[s] important interests" and "promote[s] vigorous oversight of physician performance." (Pet. App. 8a). The Eleventh Circuit nevertheless concluded the "interest of furthering discovery of probative and relevant evidence to root out invidious discrimination" outweighed "the interests to be derived from recognizing the privilege" and that "[t]he only way that [Dr.] Adkins can demonstrate the existence of disparate treatment in his case against the hospital is to compare his peer review files with the peer review files of other physician at [the hospital]." (Pet. App. 9a, 11a-12a).

The Healthcare Professionals filed a timely petition for rehearing *en banc*, which the full Eleventh Circuit denied on August 16, 2007. (Pet. App. at 48a-49a).

REASONS FOR GRANTING THE PETITION

A. The Eleventh Circuit's Decision Conflicts With This Court's Precedent

The Eleventh Circuit framed the issue before it as being whether to recognize the medical peer review privilege in "federal civil rights cases" or "federal discrimination cases." (Pet. App. 3a). In refusing to recognize the medical peer review privilege in this context, the Eleventh Circuit concluded the "interest of furthering discovery of probative and relevant evidence to root out invidious discrimination" outweighed "the interests to be derived from recognizing the privilege" and that "[t]he only way that [Dr.] Adkins can demonstrate the existence of disparate treatment in his case against the hospital is to compare his peer review

files with the peer review files of other physician at [the hospital]." (Pet. App. 9a, 11a-12a). The Eleventh Circuit's analysis is directly contrary to *Jaffee*, this Court's most recent decision analyzing when a new privilege should be recognized under Federal Rule of Evidence 501.

Specifically, in *Jaffee*, this Court determined the psychotherapist-patient privilege should be recognized as a matter of federal common law. In so doing, the Court expressly rejected the Seventh Circuit's analysis, which was the same analysis engaged by the Eleventh Circuit here – a balancing of the evidentiary need in a particular case against the broad benefit derived from the privilege. In particular, in recognizing the existence of the psychotherapist-patient privilege under Federal Rule of Evidence 501, the Seventh Circuit "qualified its recognition of the privilege by stating that it would not apply if in the interests of justice, the evidentiary need for the disclosure of the contents of a patient's counseling outweighs the patient's privacy interests." *Id.* at 7 (internal citation and quotations omitted). This Court, however, squarely rejected this reasoning and explained that recognition of a privilege does *not* depend upon the circumstances under which the claim is asserted:

> We part company with the Court of Appeals on a separate point. We reject the balancing component of the privilege implemented by that court and a small number of States. Making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the

> privilege. . . . [I]f the purpose of the privilege is to be served, the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying application by the courts, is little better than no privilege at all.

Id. at 17-18 (internal quotations and citation omitted); *see also Koch v. Cox*, 489 F.3d 384, 388-89 (D.C. Cir. 2007) ("The Court [in *Jaffee*] squarely rejected the position that a court should balance the need for relevant information in the particular case before it against the invasion of a patient's privacy."); *Nilavar*, 210 F.R.D. at 606 ("[A] privilege should either be recognized in the common law, or it should not. Its application should not turn on whether . . . the claim, which appears later in time to the occurrence of the so-called confidential communication, is one arising under malpractice law, discrimination law, or antitrust law.").

Thus, pursuant to *Jaffee*, the existence of a medical peer review privilege cannot depend upon whether the case in which the material is sought involves a claim of discrimination, as the Eleventh Circuit determined. In *Jaffee*, this Court instructed federal courts to engage in a much broader analysis, determining whether a privilege *generally* "promotes sufficiently important interests to outweigh the need for probative evidence." 518 U.S. at 9-10 (internal quotations and citation omitted). This balancing must take into account both the competing benefits and the resulting effects of recognizing (or eradicating) the privilege in its entirety, not in a particular subset of cases.

Jaffee indicates there is no basis to carve out an exception based on the potential impact on a plaintiff's ability to prove his or her case. *See id.* at 17-18. Indeed, important privileges – such as the attorney-client and therapist-patient privileges – will often apply to bar discovery of crucial evidence. The issue is whether the social interests promoted by recognition of a privilege justify permitting evidentiary restrictions that may, in certain situations, be onerous. Given the peer review privilege's obvious and critical benefits to society to enhance and ensure quality medical care and the consensus of the states for recognition of the privilege, the medical peer review privilege should be recognized in this case. *See Jaffee*, 518 U.S. at 13 ("the existence of a consensus among the States indicates that `reason and experience' support the recognition of the privilege").

Moreover, while *Jaffee* does instruct courts to look at the likely evidentiary benefit that would result from the denial of the privilege, the test articulated in *Jaffee* is a "forward looking test": what evidence would there be if everyone knew from the outset that the communications would not be privileged.

In regard to the psychotherapist-patient privilege, this Court noted that "[w]ithout [that] privilege, much of the desirable evidence . . . is unlikely to come into being. This unspoken `evidence' will serve no greater truth-seeking function than if it had been spoken and privileged." *Id.* at 13.

And the same holds true with respect to the peer review privilege. As noted, the Healthcare Professionals produced evidence in this case which showed that with the abrogation of the peer review privilege at Sumter, doctors have dramatically reduced their participation in peer review proceedings. (R1-61-

Ex. A at ¶ 6). Thus, as shown by what has transpired at Sumter, little evidentiary benefit can be derived by rejecting the medical peer review privilege, as physicians will no longer participate on peer review committees.

In addition, the Eleventh Circuit's refusal to recognize the peer review privilege in this case opens pandora's box as to the types of claims for which a plaintiff can now get access to peer review information. Indeed, in light of *Jaffee*, the Eleventh Circuit's decision cannot be read as simply limiting the discovery of peer review information to discrimination or civil rights cases. This is particularly true, given that one of the cases upon which the Eleventh Circuit principally relied – *Mem'l Hosp. v. Shadur*, 664 F.2d 1058, 1059 (7th Cir. 1981) (per curiam) – is not a civil rights case, but an antitrust case.

Thus, in view of the Eleventh Circuit's decision, any plaintiff – whether a physician, patient, prisoner, or general citizen – can wreak havoc on a hospital or other healthcare entity by baldly asserting a federal claim against it – whether it be a discrimination, antitrust, deliberate indifference, or EMTALA claim – and then seeking discovery of the hospital's peer review files without limitation, as Dr. Adkins did here. Such a result invites plaintiffs to file meritless litigation against hospitals in the hope of coercing settlement and should not be allowed. *Cf. Bell Atlantic Corp. v. Twombly*, 127 S. Ct. 1955, 1967 (2007) ("the threat of discovery expense will push cost-conscious defendants to settle even anemic cases").

Along with being contrary to *Jaffee*, the Eleventh Circuit's view that a plaintiff is entitled unfettered access to all peer review materials during his tenure at a hospital because "[t]he only way that [a

plaintiff] can demonstrate the existence of disparate treatment in his case against the hospital is to compare his peer review with the peer review files of other physicians at [the hospital]," (Pet. App. 9a), fails to recognize the realities of litigation.

Indeed, provided a viable claim exists, a plaintiff-physician has other means to prove a discrimination claim against a hospital or other healthcare professional aside from obtaining privileged and confidential peer review materials. For example, a plaintiff-physician could depose other physicians within his or her department[7] and ask them if they had ever engaged in conduct similar to that of the plaintiff, but received no adverse action. Similarly, a plaintiff-physician could depose his or her patients and/or their family members or medical personnel present during the procedures giving rise to the adverse action, and ask them what happened in the course of plaintiff's care and treatment and about any discussions these persons may have had with hospital personnel. Moreover, a plaintiff-physician could depose hospital administrators and ask them about how the peer review process is supposed to work at the hospital in general in attempt to show he was not treated the same as others, as the district suggested to Dr. Adkins. (Pet. App. 20a). In this action, Dr. Adkins chose to do none of these things, and the Eleventh Circuit rewarded his decision to do nothing to prosecute his claims.[8]

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[7] Under Georgia law, documents obtainable from original sources are not protected by the peer review privilege. *See McCall v. Henry Med. Ctr.*, 551 S.E.2d 739, 744 (Ga. App. 2001).

[8] Despite a lengthy discovery period spanning more than eight months, Dr. Adkins only deposed three people – only two being named Defendants (Dr. Deighton and Dr. Kazi). Moreover, Dr.

Given the important issue at stake, the consensus among the states to recognize a medical peer review privilege, and the conflict between the Eleventh Circuit's decision and this Court's precedent, the Healthcare Professionals respectfully maintain that certiorari is warranted.

B. The Eleventh Circuit's Decision Presents A Conflict In Approach With The Fifth Circuit And Sharpens The Current Disarray Regarding The Medical Peer Review Privilege

1. The Eleventh Circuit's Decision Conflicts In Approach With the Fifth Circuit

In *United States v. Harris Methodist Ft. Worth*, 970 F.2d 94 (5th Cir. 1992), the Fifth Circuit considered whether the government's investigation under Title VI into alleged discrimination by a hospital satisfied the Fourth Amendment's "reasonableness" requirement. The Fifth Circuit balanced "two important competing public interests": "preventing discrimination against minority health care professionals" and "the confidentiality of peer review, a process critical to the advancement of quality health care." *Id.* at 101. The Fifth Circuit recognized "an overwhelming public

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Adkins never deposed (1) any member of his department (the Department of Surgery) other than Dr. Deighton; (2) any administrator or 30(b)(6) representative of the Hospital; or (3) any original source (e.g. the patients and/or their family members, medical personnel present during the procedures performed by Dr. Adkins, and physicians in the Department of Surgery).

interest in promoting improvement in health care through the mechanism of [physician] peer review" and held that any investigation was required to protect the confidentiality of medical peer review. *Id.* (internal quotations and citation omitted).

The Fifth Circuit expressly considered the hospital's claim "that the physician peer review materials sought in the compliance review are subject to privilege." *Id.* at 103. The Court recognized Congress' findings that "peer review materials are sensitive and inherently confidential, and protecting that confidentiality serves an important public interest." *Id.* (citing 42 U.S.C. §§ 11101(5), 11137(b)). The Fifth Circuit held that the government's investigation under Title VI could not "override" those important goals. *Harris Methodist Ft. Worth*, 970 F.2d at 103. The Fifth Circuit distinguished this Court's holding in *University of Pennsylvania v. EEOC*, which had refused to endorse a privilege for academic peer review, on the ground that "the medical peer review process is a *sine qua non* of adequate hospital care." *Id.* (internal citation and quotations omitted).

The Eleventh Circuit's decision below cannot be squared with the Fifth Circuit's approval of a medical peer review privilege. The Eleventh Circuit undertook virtually the exact same balancing as the Fifth Circuit – the interest in preventing discrimination against the need to protect the integrity of the peer review process. (Pet. App. 8a-9a). In conducting that balancing, the Eleventh Circuit held that discovery of evidence to determine whether there has been discrimination is an "overriding goal" that prohibits any application of a privilege. (Pet. App. 9a). The Fifth Circuit by contrast conducted the same balancing and held that the "important public interest" in protecting

the confidentiality of medical peer review is an "overrid[ing]" goal that supports the existence of a privilege. *Harris Methodist Ft. Worth*, 970 F.2d at 103.

Although the Fifth Circuit in *Harris Methodist Ft. Worth* declined to "define the scope" of any medical peer review privilege, its opinion clearly evidences a conflict in approach with the Eleventh Circuit. This Court in *University of Pennsylvania v. EEOC* granted review based only on "what might be thought of as a conflict in approach" with another circuit, because of "the importance of the issue." 493 U.S. at 188. Protecting medical peer review – "a process critical to the advancement of quality health care," *Harris Methodist Ft. Worth*, 970 F.2d at 101 – is unquestionably an even more important issue than preserving the sanctity of academic tenure decisions, and the "conflict in approach" between the Fifth and Eleventh Circuits as at least as strong as the split in *University of Pennsylvania*.

2. The Eleventh Circuit's Decision Sharpens The Current Disarray Regarding The Medical Peer Review Privilege

Lower federal courts are currently in disarray over whether to recognize the medical peer review privilege. Every state recognizes the privilege, and federal courts are struggling to reconcile this Court's decisions in *University of Pennsylvania* and *Jaffee*.

In *University of Pennsylvania*, this Court declined to recognize a privilege for academic peer review of tenure decisions on the ground that such privilege "has no . . . historical or statutory basis." 493 U.S. at 195. In so doing, the Court appeared to engage in a balancing test, weighing the need to protect the

confidentiality of academic peer review communications against the value of the disclosure in the particular case. Specifically, the Court noted:

> We readily agree with petitioner that universities and colleges play significant roles in American society. Nor need we question, at this point, petitioners' assertion that confidentiality is important to the proper functioning of the peer review process under which many academic institutions operate. The costs that ensue from disclosure, however, constitute only one side of the balance. As Congress has recognized, the costs associated with racial and sexual discrimination in institutions of higher learning are very substantial. Few would deny that ferreting out this kind of invidious discrimination is a great, if not compelling, governmental interest. Often, . . . disclosure of peer review materials will be necessary in order for the [EEOC] to determine whether the illegal discrimination has taken place. Indeed, if there is a `smoking gun' to be found that demonstrates discrimination in tenure decisions, it is likely to be tucked away in peer review files.

Id. at 193.

This Court in *Jaffee*, in contrast, recognized a psychotherapist-patient privilege despite a lack of common law history or statutory guidance on the ground that such a privilege was essential for confidence and trust, served important public ends, and was consistent with state rules. 518 U.S. at 10-13. Furthermore, in apparent conflict with *University of Pennsylvania*, this Court in *Jaffee* expressly rejected a

balancing test of weighing the value of confidentiality against the value of disclosure in a particular case. *Id.* at 17 ("Making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege.").

Notably, the Eleventh Circuit along with the other Courts of Appeals' decisions it relied upon to reject the medical peer review privilege applied the balancing apparently approved by *University of Pennsylvania*, but rejected in *Jaffee*. (Pet. App. at 9a); *Virmani v. Novant Health Inc.*, 259 F.3d 284, 289 (4th Cir. 2001) ("We agree with [the hospital] that the privilege it seeks would serve important interests. However, as is the case in the academic context, the evidentiary benefit that will be refusing to grant a privilege for medical peer review materials in a discrimination case is potentially great. The evidence that [the plaintiff-physician] seeks is crucial to his attempt to establish that he has been the subject of disparate treatment on the basis of race and ethnicity."); *Mem'l Hosp. v. Shadur*, 664 F.2d 1058, 1061-62 (7th Cir. 1981) (per curiam) ("[I]n deciding whether the privilege asserted should be recognized, it is important to take into account the particular factual circumstances of the case in which the issue arises. . . . [T]he need for full disclosure of relevant evidence to the trier of fact, while always substantial, is particularly so in this case.").[9]

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[9] Although decided nine years earlier, *Mem'l Hosp.* applied the same balancing apparently approved by *University of Pennsylvania*.

In contrast, the federal district courts that have recognized the medical peer review privilege have engaged in an analysis consistent with *Jaffee*. (Pet. App at 17a-20a); *Hadix v. Caruso*, 2006 U.S. Dist. LEXIS 72967 (W.D. Mich. Oct. 6, 2006) (recognizing privilege in prisoner civil rights case); *Weekoty*, 30 F. Supp. 2d at 1347-48 (recognizing privilege as a matter of federal common law under Federal Rule of Evidence 501); *Cohn v. Wilkes Gen'l Hosp.*, 127 F.R.D. 117, 121 (W.D.N.C. 1989) (recognizing peer review privilege in federal antitrust action); *cf. Nilavar*, 210 F.R.D. at 607 ("If *Jaffee* were the only source of authority for the Court's decision in this case, Defendants' argument that a physician peer review privilege should be recognized would pose a close question indeed.").

Aside from engaging in the balancing rejected by *Jaffee*, the lower federal courts reliance on *University of Pennsylvania* to deny a medical peer review privilege is wrong. Indeed, a peer review privilege in the academic context is distinguishable from one in the medical context. *See Hadix*, 2006 U.S. Dist. LEXIS 72967, at *5 ("Many of the decisions which have followed the *University of Pennsylvania* decision have applied it overly broadly to contexts which were not intended by the Supreme Court and which belie the intent of Rule 501 (to allow a flexible approach to the federal common law of privilege which serves important national interests).").

Specifically, while denying an academic peer review privilege may reduce freedom in tenure decisions, denying the medical peer review privilege has the more detrimental effect of sacrificing adequate health care. *See Harris Methodist Ft. Worth*, 970 F.2d at 103 ("[U]nlike the privilege claim for faculty tenure decisions . . . the medical peer review process is *sine*

qua non of adequate hospital care.") (internal quotations and citations omitted). Moreover, "[m]edical peer review, unlike academic peer review, is variously protected by the laws of all 50 states, which shield peer review documents from civil discovery." *Hadix*, 2006 U.S. Dist. LEXIS 72967, at *6.

Furthermore, the rejection of the academic peer review privilege in *University of Pennsylvania* was based on the specific circumstances of that case. Specifically, *University of Pennsylvania* arose out of the EEOC's investigation of a Title VII charge of discrimination. In particular, following the filing of a charge, the EEOC issued a subpoena to the University of Pennsylvania seeking, among other things, certain tenure files relating to the charging party's claim. *See University of Pennsylvania*, 493 U.S. at 186. In response, the University opposed the subpoena, arguing, among other things, a common law qualified privilege against disclosure of academic peer review files should be recognized. *Id.* at 188.

In refusing to recognize the privilege, the Court based its decision on the fact that Title VII expressly provides that the EEOC is entitled to broad access to relevant evidence, subject only to a confidentiality requirement. *Id.* at 192-93. Thus, this Court reasoned that Congress had already decided the issue: it gave the EEOC the right under Title VII to obtain all evidence relevant to the charge under investigation. As such, the Court concluded that recognizing an academic peer review privilege in this context would be inconsistent with Congress' directives. *See id.* at 189 ("We are especially reluctant to recognize a privilege in an area where it appears that Congress has consider the relevant competing concerns but has not provided the privilege itself.'); *id.* at 194 ("[W]e stand behind the

breakwater Congress has established: unless specifically provided otherwise in the statute, the EEOC may obtain `relevant' evidence. Congress has made the choice. If it dislikes the result, it of course may revise the statute.").

The circumstances of this case are completely different than in *University of Pennsylvania*, as it involves neither a claim under Title VII nor the EEOC's efforts to obtain peer review information.[10] Indeed, unlike in *University of Pennsylvania*, there is simply no statute requiring the Healthcare Professionals to produce the medical peer review information as sought by Dr. Adkins.[11]

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[10] Notably, Dr. Adkins specifically elected to bypass Title VII and, instead, proceeded with his claims under 42 U.S.C. §§ 1981, 1983, and 1985.

[11] The Health Care Quality Improvement Act ("HCQIA") in no way supports abrogation of the peer review privilege. While the Act does not confer immunity from civil rights claims that does not mean it eliminated the privileges afforded to peer review committees. Indeed, this very issue was addressed by Representative Waxman, the main sponsor of the House Bill:

> The basic point to be made is that the courts should not read anything in this bill as authorizing the overriding of any State and Federal law relating to discovery. Specifically, I understand that there are a number of State shield laws that restrict the type of evidence that may be introduced in lawsuits challenging a disciplinary action in the context of peer review. Nothing in this bill is intended to preempt or override any such State shield law.

132 Cong. Rec. 33,177; *see also Virmani*, 259 F.3d at 291 ("we *cannot* conclude that Congress actually considered and rejected a privilege for medical review materials when enacting the HCQIA") (emphasis added).

Given the inconsistencies between *University of Pennsylvania* and *Jaffee*, the consensus amongst the states to recognize a medical peer review privilege, and the disarray in the lower federal courts regarding whether to recognize the privilege, certiorari is warranted.

C. This Court Should Grant Review Now To Prevent Serious Harm To Patients And The Medical System

There is no question that had this suit been filed in state court, Dr. Adkins would not be entitled to any medical peer review discovery. Indeed, contrary to the Eleventh Circuit suggestion, (Pet. App. 11a), the Georgia peer review privilege is not limited to situations involving medical malpractice; rather, it also applies to actions brought by physicians challenging the peer review process itself. *See Patton*, 539 S.E.2d 529-30; *Doe v. Unum Life Ins. Co. of Am.*, 891 F. Supp. 607, 610 (N.D. Ga. 1995) ("[T]he peer review statutes confer upon peer review organizations the qualities of a black hole."); *see also Kingsley v. Sachitam*, 783 So.2d 824, 826 (Ala. 2000) (rejecting disclosure of peer review documents in physician's action challenging negligence in performance of peer review); *Dworkin v. St. Francis Hosp., Inc.*, 517 A.2d 302, 307 (Del. Super. 1986) (medical peer review privilege applied in suit for wrongful termination of medical privileges); *Holly v. Auld*, 450 So.2d 217, 221 (Fla. 1984) (holding medical peer review discovery privilege is not limited to medical malpractice action and applies in defamation action); *Frank v. Trustees of Orange County Hosp.*, 530 N.E.2d 135, 137-38 (Ind. App. 1st Dist. 1988) (peer review information not subject to discovery in breach of

contract case brought by physician against hospital); *Doe v. Grant*, 839 So.2d 408, 416-17 (La. App. 4th Cir. 2003) (statements made during peer review meeting were protected under peer review statute in defamation and breach of contract suit brought by doctor against hospital and members of peer review committee); *St. Joseph Med. Ctr., Inc. v. Cardiac Surgery Assocs., P.A.*, 896 A.2d 304, 315-18 (Md. 2006) (peer review records protected from disclosure in unfair competition and tortious interference action); *Amaral v. Saint Cloud Hosp.*, 598 N.W.2d 379, 388 (Minn. 1999) (upholding peer review privilege from disclosure in non-medical malpractice action); *Soentgen v. Quain & Ramstad Clinic, P.C.*, 467 N.W.2d 73, 79-80 (N.D. 1991) (peer review statements were privileged in defamation and wrongful discharge suit); *Wall v. Ohio Permanente Med. Grp., Inc.* 695 N.E.2d 1233, 1238-40 (Ohio App. 1997) (finding doctor not entitled to discovery of peer review information in wrongful discharge action); *Straube v. Larson*, 600 P.2d 371, 374-76 (Or. 1979) (peer review information protected from disclosure in suit against hospital for suspending a doctor's privileges); *Irving Healthcare Sys. v. Brooks*, 927 S.W.2d 12, 20-22 (Tex. 1996) (documents and communications relating to proceedings of peer review committee are not discoverable in suit for damages when doctor claims communications to committee were made with malice); *Ragland v. Lawless*, 812 P.2d 872, 867-77 (Wash. App. 1991) (peer review records immune from discovery in suit by physician against medical society and chairmen of peer review committee).

This Court should not wait for further disagreements among the lower federal courts to resolve the critical issue of the discoverability of medical peer review information in federal cases, as the

Eleventh Circuit's abrogation of the privilege places patient care in jeopardy. Every state has carefully considered the importance of revealing medical peer review information against the importance of protecting its confidentiality, and every state has ended up in favor of recognizing a medical peer review privilege.

Under *Jaffee*, "the existence of a consensus among the States indicates that 'reason and experience' support the recognition of the privilege." 518 U.S. at 13. Furthermore, this Court has held that "general healthcare regulation . . . historically has been a matter of local concern." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651 (1995) (citation omitted). It is, therefore, particularly appropriate for federal courts to defer to the states' judgment in recognizing a medical peer review privilege. *See Jaffee*, 518 U.S. at 13 ("Denial of the federal privilege . . . would frustrate the purposes of the state legislation that was enacted to foster these confidential communications.").

This case presents an excellent vehicle through which to provide guidance to the lower federal courts. The issue is squarely presented, is outcome determinative, and is ripe for this Court's review.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request that their petition for a writ of certiorari be granted.

Respectfully submitted,
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(any footnotes trail end of each document)

No. 06-13107
UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

RUSSELL E. ADKINS, MD,
Plaintiff-Appellant,

Versus

ARTHUR P. CHRISTIE, Individually, and in his Official Capacity as the Administrator of Houston Medical Center, ANTHONY L. ALFORD, Individually and in his Official Capacity as Executive Director for Medical Affairs of Houston Medical Center, DANIEL A. DEIGHTON, Individually and in his Official Capacity as Chief of Staff and in his Official Capacity as a Member of the Medical Executive Committee at Houston Medical Center, FREDERICK W. JENNART, Individually and in his Official Capacity as a Member of the Medical Executive Committe at Houston Medical Center, DAVID N. HARVEY, MD, Individually, and in his Official Capacity as a Member of the Medical Executive Committee at Houston Medical Center, et al.,
Defendants-Appellees.

June 12, 2007, Decided

June 12, 2007, Filed

COUNSEL: For Adkins, Russell E., Appellant: Crucilla, Bernadette, Buafo & Associates, MACON, GA.

For Appellant: Buafo, Althea L., Buafo & Buafo & Associates, MACON, GA.

For Christie, Arthur P., Appellee: Koster, Paul Robert, Daley, Koster and LaVallee, LLC, ATLANTA, GA.

For Alford, Anthony L., Deighton, Daniel A., Jennart, Frederick W., Harvey, David N., Appellees: Daley, Cynthia M., Daley, Koster & LaVallee, LLC, ATLANTA, GA.

For Appellee: Smith, Rush S. Jr., Hall, Booth, Smith & Slover, PC, ATLANTA, GA.

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For The Medical Association of Georgia, Amicus: Looby, Brian William, Medical Association of Georgia, ATLANTA, GA.

For Amicus: Smith, Jack Palmer III, Alston & Bird LLP, ATLANTA, GA.

JUDGES: Before EDMONDSON, Chief Judge, BIRCH and WILSON, Circuit Judges.

OPINION BY: WILSON

OPINION

WILSON, Circuit Judge:

This appeal concerns an evidentiary privilege known as the "medical peer review privilege." The privilege seeks

to protect from discovery and disclosure records containing performance reviews and assessments of physicians by their peers, primarily in connection with their practice at hospitals. The issue before us is whether to recognize the privilege in federal civil rights cases. The Fourth and Seventh Circuits have denied the privilege in these cases. We join them in declining to recognize a privilege for documents relating to medical peer review proceedings in federal discrimination cases.

We also conclude in this opinion that the district court improperly limited the scope of discovery and, as a result, prematurely granted Defendants' motion for summary judgment.

Background

These issues arose in Dr. Russell Adkins' federal civil rights action, filed pursuant to 42 U.S.C. §§ 1983, 1981 and 1985. In his complaint, Adkins, an African-American staff physician with privileges at the Houston Medical Center ("HMC"), asserted that HMC and several HMC physicians (collectively "Defendants") discriminated against him on racial grounds in their implementation and utilization of HMC's peer review and physician disciplinary process. In conformity with Medical Staff Bylaws, Adkins was provisionally admitted to practice at HMC in 1997 for a minimum of one year. Adkins contends that during this first year, the head of the Department of Surgery, Dr. Deighton, unilaterally chose to review all of Adkins' medical charts, an unusually high level of review for new physicians. None of Adkins' cases during his first year were found to warrant further investigation by a peer

review committee. Nevertheless, HMC extended his provisional status by six months on the grounds that he allegedly failed to follow protocols for pre-admission of surgical patients, failed to complete medical records in a timely manner and had problems with availability for call. Adkins concedes that he failed to complete medical charts within the time frame dictated by HMC's Medical By-laws on eight different occasions during that time. However, he argues that such delays were a hospital-wide problem and that Deighton himself acknowledged having received warning letters for failure to complete his charts in a timely manner.

Adkins further claims that in 2001, and again in 2002, HMC imposed additional conditions on his continued employment even though he had a good record as a physician. Finally, Adkins claims that HMC deliberately mishandled the care of one of his patients, S.K., and later used that case as a pretext to take action against him. Specifically, he alleges that nurses falsified reports related to S.K.'s condition, refused to contact him about her care, and contravened his orders relating to her care, resulting in her pain and discomfort. He claims that the staff at HMC incorrectly informed S.K. that he was out of town, and deliberately withheld information about her status from him, which ensured that he was unavailable to assist her. He argues that HMC then used S.K.'s case as grounds to begin peer review of his practices, and unfairly determined that he was unavailable to assist S.K., meting out the disproportionately harsh penalties of suspension and subsequently, termination against him.

Defendants dispute this characterization of Adkins' practice at the hospital. They allege that Adkins

repeatedly experienced problems with availability for call, timely completion of medical records and failure to follow hospital protocol on patient admissions. Defendants further allege that in 2002, Adkins grossly mishandled a surgical operation on a seven-month-old infant by operating on him without proper surgical equipment, thus raising additional questions about his professional judgment. Finally, Defendants allege that peer review of Adkins' treatment of S.K. was automatically required by hospital procedure that mandated review of all patient cases involving repeat surgeries. They claim that external peer review determined that Adkins' availability and level of care was inadequate, and that in light of his record, suspension was an appropriate measure to protect the health and safety of patients at the hospital.

In May 2004, Defendants sought dismissal of Adkins' complaint for failure to state a claim on qualified immunity grounds. The district court converted this motion into one for summary judgment and initially allowed discovery on issues relating to qualified immunity only. During discovery, Adkins requested documents relating to peer review of *all* physicians at the hospital during the seven years that Adkins was a member of the hospital staff. In response, Defendants filed a motion for a protective order, arguing that Adkins was seeking information relating to the peer review process, which was covered by the Georgia medical peer review privilege.[1] Although the court concluded that the privilege applied to federal civil rights actions, it nevertheless ordered Defendants to provide Adkins with descriptions of all incidents giving rise to peer review, without disclosing the documents themselves. The court limited production to peer

review documents covering physicians it deemed similarly situated to Adkins, namely physicians in the Department of Surgery during a five-year time period, rather than documents relating to all physicians with staff privileges at HMC during the seven-year time period requested by Adkins.

In response to Defendants' motion for summary judgment, the district court undertook in-camera review of the disclosed peer review files. The court also reviewed a list identifying the race of the forty-seven physicians at HMC that were suspended in the last five years. Following this review, the court granted summary judgment in favor of Defendants. Adkins now appeals the judgment, contending that the court improperly recognized the privilege, and improperly limited the scope of his discovery request.

The Medical Peer Review Privilege

Adkins argues that the district court incorrectly ruled that federal law allows for a medical peer review privilege in discrimination cases. The decision to recognize a privilege is a mixed question of law and fact, which we review *de novo.* Fed. R. Evid. 501; *Carman v. McDonnell Douglas Corp.*, 114 F.3d 790, 793 n.2 (8th Cir.1997). While all fifty states and the District of Columbia recognize such a privilege, the Eleventh Circuit has not yet definitively ruled on whether it applies in federal court, and as we previously stated, the Fourth and Seventh Circuits have failed to recognize the privilege. *See Virmani v. Novant Health, Inc.*, 259 F.3d 284, 289 (4th Cir. 2001); *Mem'l Hosp. v. Shadur*, 664 F.2d 1058, 1063 (7th Cir. 1981) (per curiam).

Evidentiary privileges in the federal courts are governed by Fed. R. Evid. 501, which provides:

Except as otherwise required by the Constitution . . . as provided by Act of Congress, or in rules prescribed by the Supreme Court . . ., the privilege of a witness . . . shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience.Fed. R. Evid. 501.

The Federal Rules of Evidence empower the federal courts to "continue the evolutionary development of [evidentiary] privileges." *Trammel v. United States*, 445 U.S. 40, 47, 100 S. Ct. 906, 910, 63 L. Ed. 2d 186 (1980). However, these privileges remain disfavored and should not be lightly created. *United States v. Nixon*, 418 U.S. 683, 710, 94 S. Ct. 3090, 3108, 41 L. Ed. 2d 1039 (1974). The Supreme Court has cautioned that privileges "contravene the fundamental principle that the public . . . has a right to every man's evidence." *Univ. of Pa. v. EEOC*, 493 U.S. 182, 189, 110 S. Ct. 577, 582, 107 L. Ed. 2d 571 (1990) (alteration in original) (internal quotation marks omitted). Accordingly, there is a presumption against privileges which may only be overcome when it would achieve a "public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth." *Trammel*, 445 U.S. at 50, 100 S. Ct. at 912. This is a high standard, and "only the most compelling candidates will overcome the law's weighty dependence on the availability of relevant evidence." *Pearson v. Miller*, 211 F.3d 57, 67 (3d Cir. 2000).

The Supreme Court's decision in *Jaffee v. Redmond*, 518 U.S. 1, 116 S. Ct. 1923, 135 L. Ed. 2d 337 (1996), provides us with useful guidance on how to determine whether an evidentiary privilege should be created. In *Jaffee*, the Supreme Court identified some factors as relevant to the inquiry including: 1) the needs of the public good; 2) whether the privilege is rooted in the imperative need for confidence and trust; 3) the evidentiary benefit of the denial of the privilege; and 4) consensus among the states. 518 U.S. at 10-16, 116 S. Ct. at 1928-31. In deciding whether to recognize a privilege, we must consider that there is "a general duty to give what testimony one is capable of giving, and that any exemptions which may exist are distinctly exceptional, being so many derogations from a positive general rule." *Id.* at 9, 116 S. Ct. at 1928.

Defendants, joined by amicus curiae the Georgia Hospital Association, primarily rely on the needs of the "public good" to support their argument for recognizing a medical peer review privilege. They contend that the absence of the privilege would chill supervising physicians, making them less candid in their performance evaluations of staff physicians for fear that their assessments and statements might be used for improper purposes. For example, they contend that peer review materials might be used to generate medical malpractice litigation. They raise concerns about patient confidentiality. They argue that the quality of the oversight process, and thus of healthcare itself, would suffer if the privilege is not recognized.

We agree with HMC that the privilege it seeks would serve important interests. The privilege would promote vigorous oversight of physician performance. But the

privilege must be considered against a corresponding and overriding goal -- the discovery of evidence essential to determining whether there has been discrimination in employment. Guided by the principles disfavoring privileges, as well as the *Jaffee* factors, we conclude that the medical peer review process does not warrant the extraordinary protection of an evidentiary privilege in federal civil rights cases. Here, we are confronted with a claim of racial discrimination within the peer review process itself, implicating the important social goal of eliminating employment discrimination. *See, e.g., Univ. of Pa.*, 493 U.S. at 193, 110 S. Ct. at 584 (finding that exposing "invidious discrimination is a great, if not compelling governmental interest").

Further, the documents that HMC seeks to protect are critical to Adkins' discrimination claims. The only way that Adkins can demonstrate the existence of disparate treatment in his case against the hospital is to compare his peer review with the peer review files of other physicians at HMC. In *Shadur*, the Seventh Circuit was similarly confronted with a situation where recognizing a medical peer review privilege would effectively bar a plaintiff's claim. *Shadur*, 664 F.2d at 1062-63. In that federal antitrust action, Plaintiff sought medical peer review materials in order to demonstrate that the Defendant physicians used the review process discriminatorily in furtherance of a conspiracy to destroy his practice and thus limit competition. *Id* at 1063. Taking into account the compelling public policy favoring such antitrust actions, the court found that the privilege should not be recognized when it would prevent the plaintiff from asserting his claim altogether. *Id.* In *Virmani*, the Fourth Circuit was

similarly guided by the evidentiary benefit presented by peer review documents in employment discrimination cases. 259 F.3d at 289. Confronted with a claim virtually identical to the one at hand, the court found that "[t]he interest in facilitating the eradication of discrimination by providing perhaps the only evidence that can establish its occurrence outweighs the interest in promoting candor in the medical peer review process." *Id.*

We recognize that health care providers, like HMC and its supervising physicians, have a legitimate interest in keeping peer review documents confidential and in protecting them from widespread dissemination. However, "[t]here is an important distinction between privilege and protection of documents, [with] the former operating to shield the documents from production in the first instance, [and] the latter operating to preserve confidentiality when produced." *Id.* at 288 n.4. In the absence of the privilege, the district court retains its authority to protect HMC's interests through other established means such as protective orders, confidentiality agreements, and when appropriate, by disclosure only after an in-camera review of these documents. *See, e.g., Kerr v. United States District Court*, 426 U.S. 394, 405, 96 S. Ct. 2119, 2125, 45 L. Ed. 2d 725 (1976) (noting that methods such as in-camera review of documents can be used to balance a party's need for confidentiality against an adverse party's need for evidence);*Marrese v. American Acad. of Orthopaedic Surgeons*, 726 F.2d 1150, 1160 (7th Cir. 1984) (*en banc*) (noting that there are different ways for district courts to protect non-privileged documents) *rev'd on other grounds*, 470 U.S. 373, 105 S. Ct. 1327, 84 L. Ed. 2d 274 (1984). The district

courts are well-equipped with a variety of mechanisms to ensure that peer review materials, once furnished through discovery, are not compromised by wayward hands, i.e., redaction of extraneous or confidential information, in-camera review and protective orders. The "public good" concerns advanced by the defendants may capably be served in the absence of a medical peer review privilege.

We are mindful of the fact that a medical peer review privilege is recognized by all fifty states and the District of Columbia, a factor that *Jaffee* lists in Defendants' favor. The Fourth Circuit addressed this argument in *Virmani*, and rejected that factor on the grounds that there is a strong evidentiary benefit to be obtained in a discrimination case, and that the state statutes address different policy concerns when they balance the need for candor in peer review discussions against a plaintiff's access to evidence in a malpractice suit. 259 F.3d at 290-91. The interests at issue in a discrimination claim like this one are different from that of a malpractice case, and merit a different analysis. As the *Virmani* court correctly observed, "[t]here is no evidence that state legislatures considered the potential impact on discrimination cases of a privilege for medical peer review proceedings." *Id.* at 291. We agree that "the states' policy decisions, reflecting different concerns than those implicated here, [should] not inform the judgment of the court in this case." *Id.* Declining to recognize a medical peer review privilege in federal discrimination cases provides a strong evidentiary benefit. Balancing the interests to be derived from recognizing the privilege against the interest of furthering the discovery of probative and

relevant evidence to root out invidious discrimination, we decline to recognize the privilege.

Scope of Discovery

Although the district court announced its recognition of the privilege, it still ordered some limited discovery. Adkins sought to compel production of peer review materials of *all* physicians at HMC during the seven-year period that he was employed there. The district court limited Adkins' inquiries to those involving physicians in the Department of Surgery and to the five-year period preceding his suspension.

We generally review the district court's efforts to manage discovery for abuse of discretion. *Burger King Corp. v. Weaver*, 169 F.3d 1310, 1315 (11th Cir. 1999). However, if we find that in limiting discovery, the district court "made a clear error of judgment . . . or . . . applied an incorrect legal standard," we must reverse that decision. *Peat, Inc. v. Vanguard Research, Inc.*, 378 F.3d 1154, 1159 (11th Cir. 2004) (citing *Alexander v. Fulton County*, 207 F.3d 1303, 1326 (11th Cir. 2000)). Here, we find that the district court made such an error in concluding that review of physicians outside Adkins' department and beyond the five-year time limit was not relevant to the case at the bar.

Under the Federal Rules of Civil Procedure, discovery is limited to "matter[s], not privileged, that [are] relevant to the claim or defense of any party." Fed. R. Civ. P. 26(b)(1). "Relevant information need not be admissible at the trial if the discovery appears reasonably calculated to lead to the discovery of admissible evidence." *Id.* In this case, HMC argues that

adverse employment action was taken against Adkins in light of his performance during his tenure. By arguing that his record fell below standards the hospital used to judge its physicians, HMC itself put the record and peer review of other physicians at issue. Comparison to disciplinary measures against them is therefore clearly relevant to the case.

HMC argues that any comparison should be limited to physicians in the Department of Surgery since they are the only ones that are "similarly situated" to Adkins. *See Wilson v. B/E Aerospace Inc.*, 376 F.3d 1079, 1091 (11th Cir. 2004). We do not agree. While the Department of Surgery is an autonomous unit within the Hospital, some of the infractions at issue arose from hospital-wide rules, such as the requirement to complete medical charts in a timely manner. Additionally, Adkins is entitled to compare the general standard that hospital physicians were held to in order to establish that his punishment was excessive. The limited number of physicians in the Department of Surgery does not allow Adkins to place his case in the context of larger disciplinary processes of the hospital and thus place an excessive burden on his ability to pursue his claim.

We note that although district courts have broad discretion in fashioning discovery rulings, they are bound to adhere "to the liberal spirit of the [Federal] Rules." *Burns v. Thiokol Chem. Corp.*, 483 F.2d 300, 305 (5th Cir.1973). The Federal Rules do not give district courts "blanket authorization . . . to prohibit disclosure of information whenever it deems it advisable to do so, but is rather a grant of power to impose conditions on discovery in order to prevent injury, harassment, or

abuse of the court's processes." *Williams v. City of Dothan, Ala.* 745 F.2d 1406, 1416 (11th Cir. 1984) (quoting *Bridge C.A.T. Scan Assocs. v. Technicare Corp.*, 710 F.2d 940, 944-45 (2d Cir. 1903)). The Defendants have failed to demonstrate a burden or an abuse of process sufficient to justify such limitations on discovery, especially in light of the highly relevant nature of the materials sought by Adkins. Although we acknowledge that the district court's limits were aimed in part at protecting the confidentiality of Defendants' documents, these limits excessively narrowed the scope of discovery. We therefore conclude that Adkins was entitled to greater latitude in order to access documents relevant to his discrimination claim, and the district court erred by denying Adkins the opportunity to compel production of a wider range of documents.

Summary Judgment

Adkins further challenges the district court's grant of summary judgment in favor of Defendants. In light of the improper limitations on Adkins' ability to conduct discovery, we conclude that Adkins was denied the opportunity to proffer evidence in response to the summary judgment motion. *Burns*, 483 F.2d at 308 n.11. We therefore vacate the grant of summary judgment in order to allow the parties to engage in discovery in accordance with this opinion. Accordingly, the decision of the district court is vacated and remanded.

VACATED AND REMANDED.

Footnote

[1]Georgia requires that "[t]he proceedings and records of medical review committees shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by such committee." O.C.G.A. § 31-7-143. The Georgia Supreme Court has interpreted this statutory mandate as placing "an absolute embargo upon the discovery and use of all proceedings, records, findings, and recommendations of peer review groups and medical review committees in civil litigation." *Emory Clinic v. Houston*, 258 Ga. 434, 369 S. E. 2d 913, 913 (1988) (per curiam).

11/10/04
5:04-CV-80 (WDO)
IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION

DR. RUSSELL ADKINS, Plaintiff
v.
THE HOSPITAL AUTHORITY OF HOUSTON COUNTY, et al., Defendants

ORDER

This matter is before the court on the defendants' motion for protective order. Defendants seek to protect from discovery the documents pertaining to the peer review proceedings conducted at Houston Medical Center. After a thorough review of the documents in question and after careful consideration of the parties' briefs and arguments presented during the hearing, the court enters the following order.

Plaintiff, Dr. Russell Adkins, filed this suit against the Hospital Authority of Houston County and members of Houston Medical Center's Medical Executive Committee claiming that his hospital privileges were suspended in violation of 42 U.S.C. § 1981, and several state laws. Prior to the suspension of his privileges, the hospital conducted what is known as a "peer review" process during which certain allegations against Dr. Adkins were investigated. After the peer review process concluded, the Hospital Authority voted to suspend Dr. Adkins' relieve it of the obligation to respond to the discovery requests. This motion may be considered by the court when the discovery sought

would cause "undue burden or expense" on the party from whom the information is sought. Id. at (c). Federal Rule of Evidence 501 provides that ". . . the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience."

The district court has broad discretion to control discovery. Phipps v. Blakeney , 8 F.3d 788, 790 (11th Cir.1993). District courts have "the ability ... to police discovery simply and speedily." Id. For example, the court can order "that certain matters not be inquired into, orthatthescope of the disclosure or discovery be limited to certain matters." Id.

The Eleventh Circuit Court of Appeals has not addressed the issue of a "peer review" privilege in the context of a discrimination case. However, there is some guidance from the Supreme Court on how district courts are to determine whether to recognize certain privileges. Finally, there is some case law from the district courts in this circuit and others that have addressed the peer review privilege specifically.

One of the leading cases that explains the process of recognizing an evidentiary privilege is Jaffee v. Redmond, 518 U.S. 1, 116 S. Ct. 1923, 135 L.Ed.2d 337 (1996). In Jaffee, the Supreme Court for the first time recognized a privilege protecting confidential communications between a psychotherapist and her patient. After noting that, generally, evidentiary rules disfavor privileges, the court analyzed the following factors to determine whether the privilege should be

recognized exceptions from the general rule may be justified by a public good that transcends the normally predominant principle of utilizing all rational means for ascertaining the truth;

2. federal courts are governed by common law principles that are to be applied in light of reason and experience;
3. a consensus among the States regarding whether a privilege should be recognized is an important factor for courts to consider;
4. courts should make the decision whether to recognize a privilege on a case-by-case basis;
5. the mental health of our citizenry, no less than its physical health, is a public good of transcendent importance;
6. consider the likely evidentiary benefit that would result from the denial of the privilege;
7. determine whether the privilege is rooted in the imperative need for confidence and trust; and
8. consider that the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected because an uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.

Doe v. UNUM Life Ins. Co. of America involved a dispute between a physician and his insurer over the physician's alleged drug use prior to applying for disability insurance. Doe v. UNUM Life Ins. Co. of America, 891 F. Supp. 607 (N. D. Ga.1995). As part of the discovery process, the insurer sought information

from a hospital regarding why the physician's hospital privileges had been suspended. The physician and non-party hospital filed a motion to quash the subpoena arguing that the materials were protected by the peer review privilege. The court, recognizing that Georgia has legislatively and judicially adopted the peer review privilege, granted the hospital's motion for a protective order. The court first noted that the Georgia statutes "place an exceedingly wide blanket of confidentiality over information generated by health care providers concerning the quality and efficiency of medical care." Id. at 609. The court explained that "the peer review statutes confer upon peer review organizations the qualities of a black hole; what goes in does not come out, and, unless the information exists in duplicate in the surrounding orbit, nothing that went in is discoverable." Id. at 610.

In the case bar, the defendants established several compelling reasons to recognize the peer review privilege under the particular circumstances of this case. First, all of the factors listed above from Jaffee are met. Second, it is certainly in the interest of the public that the documents at issue be protected from disclosure. The peer review process, as it relates to the plaintiff and the other physicians, serves as an integral part of the hospital's fulfillment of its duty to provide the best health care available and to ensure that any physicians who, for whatever reason, are not performing up to the hospital's expectations are subjected to a suspension of their hospital privileges.

As for the other factors, another compelling reason to recognize the privilege in this case is that the State of Georgia has unequivocally created a privilege for all

matters emanating from the medical peer review process. See O.C.G.A. §§ 31-7-133, 31-7-143. Further, the numerous cases cited by the defendants show that all 50 States and the District of Columbia have adopted some form of the privilege and 46 of those States have enacted legislation recognizing the privilege. See Weekoty v. United States, 30 F. Supp.2d 1343, 1346 (D.N.M. 1998) (citing Sanderson v. Frank S. Bryan, M.D., Ltd., 361 Pa. Super. 491, 495 n. 3, 522 A.2d 1138, 1140 n. 3 (Pa. Super. Ct.1987)). Therefore, the defendants established a consensus among the States that the privilege should be recognized. There is little or no evidentiary benefit that would result from the denial of the privilege in this case because the information the plaintiff seeks may very well be obtained from other sources such as through depositions of hospital administrators regarding general information about the hospital's policies and procedures for the peer review process and whether other individuals have been subjected to the same. Finally, the defendants' desire to protect the peer review documents is rooted in the imperative need for confidence and trust because this case involved a group of physicians passing judgment on their colleagues who had been accused of various wrongdoings or omissions.

After careful thought and reflection on the above factors and consideration of the parties' arguments, the court hereby GRANTS the defendants' Motion for Protective order as to all peer review materials requested by the plaintiff. See R. at 56. However, this order does not prohibit either party from using any information in their possession to support or defend any claims asserted in this case. The court will leave it up to the parties to decide whether to disclose the

confidential materials in their possession.

Finally, because the court returned all documents that were submitted for in camera review, other than the peer review materials that pertain specifically to the plaintiff, the plaintiff's Motion for Leave to Submit Information Under Seal is DENIED AS MOOT. See R. at 79.

SO ORDERED this 10th day of November, 2004.

WILBUR D. OWENS, JR.
UNITED STATES DISTRICT JUDGE

5/2/06
UNITED STATES DISTRICT JUDGE
5:04-CV-80 (WDO)

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

RUSSELL ADKINS, M.D.,
Plaintiff
v.

THE HOSPITAL AUTHORITY OF HOUSTON COUNTY, et al.,
Defendants

ORDER

Dr. Russell Adkins brought this case alleging that his hospital privileges at Houston Medical Center were suspended because of his race, African-American. He sued the hospital, numerous doctors, the Hospital Administrator and the governing authority of the hospital, the Hospital Authority of Houston County, asserting claims pursuant to 42 U.S.C. § 1981, § 1983 and § 1985(3) as well as various state law claims. As to the § 1983 claims, Dr. Adkins contends that (1) the Defendants violated his right to equal protection by summarily suspending and not renewing his privileges based on his race and (2) the Defendants took these actions without affording him due process. The § 1981 claims are that the Defendants discriminated against Dr. Adkins in the making, performance and enforcement of his contractual relationship with his patients. The §1985 claims are that the Defendants conspired to deprive Dr. Adkins of various

constitutional rights. Defendants filed motions to dismiss arguing that Dr. Adkins failed to state a claim on which relief can be granted and on the basis of qualified immunity. The Court declined to rule on the motion to dismiss and instead ordered the parties to engage in discovery and thereafter file motions for summary judgment. After an extensive discovery period, the Defendants have now moved for summary judgment. After carefully considering the entire record, the Court finds that another hearing is unnecessary and makes the following findings.

The Medical Executive Committee of Houston Medical Center is the representative body for the hospital's medical staff and consists of officers of the medical staff and the Chairmen of the various departments. One of the MEC's duties is to review the qualifications, credentials, performance, professional competence and character of applicants and staff members and make recommendations to the Hospital Authority regarding staff appointments, clinical privileges and corrective actions. The Hospital Authority independently reviews the physicians' files and makes independent decisions regarding whether to approve or deny the MEC's recommendations. Pursuant to the Bylaws, "The Hospital Authority may affirm, modify or reverse the prior decision or, in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within ten (10) business days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specified issues."[1] The MEC may summarily suspend a physician when it feels action must be taken immediately to protect the health or safety of patients.

Pursuant to the hospital's bylaws, each Department in the hospital is an autonomous unit that formulates its own policies and procedures and has its own Department Chair. The Chair of each Department examines the licensure, character, professional competence, qualifications and ethical standing of physicians applying for privileges within that Department. The Departments, as much as is practical, are autonomous units coordinating their efforts through the Medical Executive Committee and other Committees of the Staff as necessary for administrative functioning. Each Department establishes criteria for the granting of Clinical Privileges within the Department and submits recommendations regarding the specific Clinical Privileges each Staff Member or Applicant may exercise. Each Department adopts a written Departmental code containing rules and regulations that are reviewed, amended and approved by each Department. The Department of Surgery is listed as a separate department that did in fact adopt its own Rules and Regulations.

In 1997, Dr. Adkins applied for provisional medical staff membership in the Department of Surgery at Houston Medical Center. The application was approved subject to the standard provisions that he consult with another surgeon on the first 25 patients admitted to the hospital and be observed by another surgeon on the first 10 surgeries performed at the hospital. In early 1998, the Hospital Authority approved Dr. Adkins' application for provisional active staff membership. During the provisional period, Dr. Adkins experienced problems with being available for call, following preadmission protocol and completing his medical records on time. For instance, the hospital required patients who were

undergoing surgical procedures to have consents and blood work done prior to the day of surgery. However, Dr. Adkins would not require his patients to follow these rules which would result in his patients' surgeries and the schedule for the entire Department of Surgery being delayed and the need for additional staff. When Dr. Adkins later applied to change from a provisional status to active status, the MEC recommended that the Hospital Authority extend Dr. Adkins' provisional status for 6 months to monitor his performance in following preadmission protocol. In 1999, the Hospital Authority extended his provisional status for 6 months so he could be monitored on preadmission protocol, timely completion of medical records and availability for and timely response to calls from the hospital. At the end of the provisional period, Dr. Adkins' status changed to "active" membership.

In June of 2001, Dr. Harvey, the Chief of Staff at the time, was contacted by Outpatient Surgery when no one was able to reach Dr. Adkins regarding one of his surgical patients who was experiencing complications in the recovery room. Dr. Harvey beeped Dr. Adkins and received no response. Dr. Harvey then contacted Dr. Adkins' office and learned that Dr. Adkins had left the call area without arranging for anyone to cover for him. Dr. Adkins contends his pager was not working properly at the time. Following an investigation, Dr. Adkins received a letter of admonishment regarding his unavailability.

In late 2001, Dr. Adkins submitted his application for reappointment. The Credentials Committee determined that (1) Dr. Adkins' attendance at medical staff meetings fell below the 50% required by the Bylaws, (2)

Dr. Adkins continued to have problems being available for calls and (3) Dr. Adkins had multiple suspensions for failure to timely complete his medical records. As a result, his reappointment was granted with the stipulations that he attend 100% of his meetings for 6 months and that his medical charts would be monitored for 6 months.

In March of 2002, Dr. Adkins posted a surgical case on the bulletin board for a 7-month-old male patient to perform an open procedure to repair an obstruction in the infant's kidney that was diagnosed in January of 2002. The anesthesiologist who reviewed the posting informed Dr. Adkins that such a procedure was not appropriate at Houston Medical Center because it is not a pediatric facility and is not properly equipped to handle any complications which could arise. Rather than transferring the child to another facility, which was an option considering the matter was not an emergency, Dr. Adkins removed the posting from the schedule and proceeded to perform a closed procedure of placing a stint in the child's kidney. Because of complications that arose during the surgery, Dr. Adkins was unable to perform the surgery and, rather than transferring the child to another facility, ordered the nurse to procure an adult uretaoscope and adult male dialotors. When the nurse questioned Dr. Adkins about using adult male instruments on the infant, Dr. Adkins ordered her to do as she was told because the infant's penis is a "muscle that would stretch." Dr. Adkins used the adult instruments to manipulate the child's urethra but lost the stint inside the child before it could be placed. Dr. Adkins eventually retrieved the stint and placed it. Following this procedure, internal complaints were made by the operating room personnel to the

Department of Surgery and an investigation ensued.

Dr. Alford, the Medical Director and a Defendant in this case, conducted the investigation. He interviewed the personnel involved in the surgery and attempted to interview Dr. Adkins but Dr. Adkins refused to discuss the matter after he was informed that Dr. Alford intended to tape-record the interview, as he had done in all the other interviews. After Dr. Alford completed the investigation, he submitted the transcribed witnesses' statements and the pertinent medical records to the Performance Improvement Committee ("PIC"). The PIC sent the matter out for two external peer reviews that resulted in the following findings:

- the procedure was not emergent;
- Dr. Adkins' decision to perform the procedure was inappropriate as the procedure of choice for an infant male in that situation rarely requires temporary drainage but requires a procedure that would avoid trauma to the infant's lower urinary tract;
- there were concerns regarding the management of the infant and not being able to confirm adequate instruments were available before the procedure began;
- the dilation of the urethra and distal ureter in a male infant was inappropriate even though the outcome may not be immediately apparent; and
- potential future problems for the baby include permanent disability with recurrent stricture, incontinence, urinary tract infections, renal insufficiency and the need for multiple corrective surgeries.

From these findings, the external peer reviewers concluded that (1) the documentation did not support

the need for surgery, (2) the diagnosis was confirmed, (3) the surgical technique was not appropriate, (4) the procedure was not appropriate, (5) the medical judgment was not appropriate and (6) there was an error in judgment and technique. The Department of Surgery submitted the reports to the Credentials Committee. Those reports along with those of the PIC were sent to the MEC. The MEC thereafter invited Dr. Adkins to meet with them to discuss the findings. Dr. Adkins met with the MEC and, following that meeting, the MEC restricted Dr. Adkins, as well as the other two urologists at the hospital, from performing any future complex pediatric cases at the hospital unless they were cleared by the Department Chairman.

A few months later, the PIC received a complaint from a female patient regarding another surgery performed by Dr. Adkins. Because the patient returned to surgery within 31 days of admission the case triggered a Departmental peer review, as the record shows happened with any patient who presented to the hospital within 31 days of a previous admission. The case was referred to the PIC. After the initial complaint, the patient also filed a complaint with the Joint Commission for Healthcare Accreditation Organization ("JCHAO"). The JCHAO requested a response from the hospital pursuant to which the MEC formed an Ad Hoc committee to investigate the matter.

As a result of the investigation, the hospital learned that Dr. Adkins had performed a bladder sling and a rectocele procedure on the patient on June 24, 2003. Three weeks after the procedure, the patient was still experiencing bleeding and eventually noticed surgical gauze hanging out of her vagina. Upon discovering the

gauze, the patient went to Dr. Adkins' office where he examined her and determined that he needed to oversew the incision area because the gauze was grafting material he had used during the surgery.[2] The following morning, the patient awoke covered in a pool of blood and realized she was bleeding profusely from her vagina. The patient's husband took her to the emergency room and informed the doctors that Dr. Adkins had operated on her three weeks previously and had seen her the day before to repair the incision area. Because the patient was in horrible pain, she refused to allow the emergency personnel to examine her and Dr. Adkins was contacted. The patient requested to speak with Dr. Adkins on the telephone and when she did Dr. Adkins told her he was out of own and that she needed to allow the emergency room physician to examine her. Dr. Adkins admitted in his discovery responses that he was in fact more than 30 miles from the hospital on that date. The emergency personnel attempted to examine the patient again and she refused due to the extreme pain so Dr. Adkins was contacted again. Over the phone, Dr. Adkins admitted the patient and ordered pain medication for her. However, he did not inform any hospital personnel that he was out of town or that he had asked Dr. Deighton to cover for him, although Dr. Deighton was informed he needed to cover for Dr. Adkins beginning on Saturday and the patient came into the emergency room on Thursday. Later in the afternoon, the nursing staff contacted Dr. Adkins regarding the patient's bleeding and continual complaints of pain. Dr. McBride, the surgeon on call, was contacted, evaluated the patient and contacted Dr. Deighton to examine the patient as her problem was urological. Three hours later, Dr. Adkins finally arrived at the hospital and reported to the operating room

where Dr. Deighton was about to begin operating on the patient. Dr. Deighton offered to turn the matter over to Dr. Adkins but Dr. Adkins asked Dr. Deighton to proceed with the surgery because he was already scrubbed and ready. After the surgery, Dr. Deighton replaced Dr. Adkins as the patient's physician.

After conducting the investigation into the complaints regarding the female patient, the PIC made the following findings:

- in violation of the Bylaws, Dr. Adkins admitted a patient when he could not respond appropriately and failed to inform the hospital that anyone was covering for him;
- Dr. Adkins failed to timely complete the patient's medical records as her June 24-27, 2003 admission was not dictated until September 9, 2003;
- there was an extreme discrepancy in the amount of blood loss reported by the anesthesiologists and indicated by Dr. Adkins in the medical records;
- Dr. Adkins operated on a patient and left town without arranging for appropriate coverage;
- the external peer review had also noted problems with the medical records, the discrepancy in the blood loss reported, the lack of follow-up care after surgery and the lack of any note in the medical record regarding the July 16 admission;
- there were reports that Dr. Adkins discussed the patient's care with her husband in the hallway where other individuals could overhear the conversation; and
- all of the aforementioned issues demonstrated a lack of professional judgment.

In September of 2003, the MEC recommended renewal

of Dr. Adkins' privileges with warnings regarding his timeliness of completing reports and his availability. He was notified that his patients would be monitored by another physician for 6 months. The Hospital Authority rejected the limited renewal recommendation and requested the MEC to reconsider its recommendation after receiving the final report regarding Dr. Adkins' treatment of the female patient. At the October 6, 2003 meeting, the MEC voted to suspend Dr. Adkins for 60 days, the reasons given for which were that the suspension was in furtherance of quality healthcare and to protect the health and safety of patients at the hospital. The MEC also recommended that the Hospital Authority deny Dr. Adkins' application for reappointment. Dr. Adkins was informed of the adverse action and advised of his hearing rights. Dr. Adkins declined, in writing, to attend or otherwise participate in the hearing. On March 22, 2004, the Hearing Committee recommended denying Dr. Adkins' application for reappointment. After reviewing the recommendation, the MEC voted to summarily suspend Dr. Adkins for 60 days and recommended that the Hospital Authority deny Dr. Adkins' application. The Hospital Authority accepted the recommendation and Dr. Adkins' privileges were suspended.

After Dr. Adkins filed this suit against the Defendants and the parties began to engage in discovery, serious issues arose regarding the scope and relevance of the discovery sought by Dr. Adkins. After several hearings and orders, the Court eventually ordered Defendants to produce discovery related only to events that occurred within 5 years of Plaintiff's termination, from May 26, 1999 to May 26, 2004, and only on those individuals who were "similarly situated" to Dr. Adkins, as explained

more thoroughly below. Defendants produced redacted information to Plaintiff regarding the incidents that occurred with other physicians who were disciplined in some way and produced Dr. Adkins' peer reviews. The actual peer reviews and credentialing files of the other physicians were produced to the Court for an in camera review and covered periods of time far beyond that ordered by the Court.[3] Based on the foregoing factual findings and a thorough examination of the peer review material submitted in camera, the Court makes the following legal findings.

Qualified Immunity

Defendants raised the defense of quality immunity. That is, Defendants claim that Dr. Adkins failed to allege a custom, policy or practice of the hospital that was the moving force of any constitutional violation and failed to show that the individual Defendants violated any of Dr. Adkins' clearly established constitutional rights. The Hospital Authority and the individual Defendants are "state actors" pursuant to Faucher v. Rodziewicz, 891 F.2d 864, 868 (11th Cir. 1990). Although the individual Defendants argue that some of them should not have been sued because they did not attend certain meetings or attended and abstained from voting at the meetings, for purposes of this order the Court finds they were all "government actors."

"Local governing bodies ... can be sued directly under § 1983 for monetary, declaratory, or injunctive relief where. . . the action that is alleged to be unconstitutional implements or executes a policy statement, ordinance, regulation, or decision officially adopted and promulgated by that body's officers."

Monell v. Department of Social Services, 436 U.S. 658, 690, 98 S. Ct. 2018 (1978). Courts may not hold a party, such as the hospital in this case, liable solely under a theory of respondent superior. Id. at 691. The threshold inquiry a court must undertake in a qualified immunity analysis is whether a plaintiff's allegations, if true, establish a constitutional violation. Hope v. Pelzer, 536 U.S. 730, 736, 122 S. Ct. 2508, 153 L. Ed.2d 666 (2002) (citing Saucier v. Katz, 533 U.S. 194, 201, 121 S. Ct. 2151, 150 L. Ed.2d 272 (2001)). If no constitutional right was violated, "there is no necessity for further inquiries concerning qualified immunity." Saucier, 533 U.S. at 201. The qualified immunity defense "embodies an `objective reasonableness' standard, giving a government agent the benefit of the doubt," provided that the conduct was not "so obviously illegal in the light of then-existing law. Crosby v. Paulk, 187 F.3d 1339, 1344 (11th Cir. 1999) (quoting GJR Invs., Inc. v. County of Escambia, 132 F.3d 1359, 1366 (11th Cir. 1998)). The circumstances that confronted the government actor must have been so "materially similar" to prior precedent that it constituted clearly established law because "public officials are not obligated to be creative or imaginative in drawing analogies from previously decided cases." Id. (citations omitted). "For qualified immunity to be surrendered, pre-existing law must dictate, that is, truly compel (not just suggest or allow or raise a question about), the conclusion for every like-situated, reasonable government agent that what defendant is doing violates federal law in the circumstances." Id.

Generally, in analyzing §1981 and §1983 claims, courts follow the same burden-shifting framework used in Title VII cases. Standard v. A.B.E.L. Services, Inc., 161

F.3d 1318 (11th Cir. 1998) (Title VII and 42 U.S.C. § 1981 and § 1983 have the same requirements of proof and use the same analytical framework.); McDonnell Douglas Corp. v. Green, 411 U.S. 792, 802, 93 S. Ct. 1817, 36 L. Ed.2d 668 (1973). However, Dr. Adkins' §1981 claims must be dismissed because § 1983 is the exclusive federal remedy for alleged § 1981 violations when the claim is pressed against a state actor. Jett v. Dallas Independent School Dist., 491 U.S. 701, 735 (1989); Butts v. County of Volusia, 222 F.3d 891, 894 (11th Cir. 2000) (Civil Rights Act of 1991 did not affect the continuing validity of Jett). Finally, because public officials cannot raise a qualified immunity defense to a § 1985(3) claim, that claim is addressed separately below. Burrell v. Board of Trustees of Ga. Military College, 970 F.2d 785, 794 (11th Cir. 1992).

The threshold inquiry this Court must undertake is whether Dr. Adkins' allegations, if true, establish a constitutional violation. If he has not shown that any of his constitutional rights were violated, there is no necessity for further inquiries concerning qualified immunity and the Court must grant summary judgment in favor of Defendants. Since the qualified immunity defense embodies an objective reasonableness standard, the Court must give the Defendants the benefit of the doubt, provided that Dr. Adkins' termination was not obviously illegal in light of then-existing employment discrimination law.

"Direct evidence of discrimination is evidence, that, `if believed, proves the existence of a fact in issue without inference or presumption.'" Vickers v. Federal Express Corp., 132 F. Supp.2d 1371, 1378 (S.D. Fla. 2000) ("Racially derogatory statements can be direct

evidence if the comments were (1) made by the decisionmaker responsible for the alleged discriminatory act and (2) made in the context of the challenged decision.") (quoting Burrell v. Board of Trustees of Ga. Military College, 125 F.3d 1390, 1393 (11th Cir.1997)). Such evidence is generally comprised of specific statements, conduct or attitudes by employment decision makers that reflect a bias or discriminatory animus toward a particular protected class. Dr. Adkins presented no evidence of any statements or other conduct by the Defendants that indicated Dr. Adkins was suspended because he is an African-American nor is there any evidence in the record that could be construed as direct evidence of discrimination.

"Where direct evidence of discrimination is absent, a plaintiff establishes a circumstantial, prima facie case of racial discrimination based on disparate treatment by showing several things: (1) he belongs to a racial minority; (2) he was subjected to [an] adverse job action; (3) his employer treated similarly situated employees outside his classification more favorably; and (4) he was qualified to do the job." Knight v. Baptist Hosp. of Miami, Inc.,, 330 F.3d 1313, 1316 (11th Cir. 2003) (citing Holifield v. Reno, 115 F.3d 1555,1561-62 (11th Cir. 1997) (citing McDonnell Douglas Corp. v. Green, 411 U.S. 792, 93 S. Ct. 1817, 1824-25, 36 L.Ed.2d 668 (1973))). Dr. Adkins satisfied the first, second and fourth prongs of a prima facie case. What the court must determine is whether Dr. Adkins was suspended or disciplined for conduct that similarly situated, non-AfricanAmerican physicians were not.

Although Dr. Adkins concedes he had a continuing

problem completing his medical records on time, he contends other physicians had the same problems and that he handled his surgical cases in the manner he thought was appropriate at the time. However, the record shows that the entire time he was employed at the hospital he continually violated the written policies and procedures as alleged by the Defendants. What is important is that these events were documented in the record but even if the events did not actually occur, they can be considered if the decision-makers honestly believed they occurred. Knight, 330 F.3d at 1318 n.6 (citing Jones v. Gerwens, 874 F.2d 1534, 1540 (11th Cir.1989) ("The law is clear that, even if a Title VII claimant did not in fact commit the violation, an employer successfully rebuts any prima facie case of disparate treatment by showing that it honestly believed the employee committed the violation.")). An employer's legitimate, nondiscriminatory reason, even if based on a mistaken belief, will not subject an employer to liability if that belief is subsequently proven to be an incorrect one. Moore v. Sears, Roebuck & Co., 683 F.2d 1321, 1323 n.4 (11th Cir. 1982) (the court "need only determine that the defendant in good faith believed plaintiff's performance to be unsatisfactory") (citations omitted). An employer has a right to interpret its rules as it chooses and to make determinations as it sees fit under those rules because the anti-discrimination statutes only prohibit discrimination. Nix v. WLCY Radio/Rahall Communications, 738 F.2d 1181, 1187 (11th Cir. 1984) (citation omitted).

The Eleventh Circuit Court of Appeals has admonished, "federal courts do not sit as a super-personnel department that reexamines an entity's

business decisions. No matter how medieval a firm's practices, no matter how high-handed its decisional process, no matter how mistaken the firm's managers, [courts do] not interfere. Rather our inquiry is limited to whether the employer gave an honest explanation of its behavior." Chapman v. AI Transport, 229 F.3d 1012, 1030 (11th Cir. 2000) (citation omitted). Federal courts "are not in the business of adjudging whether employment decisions are prudent or fair." Id. (citation omitted). "An `employer may fire an employee for a good reason, a bad reason, a reason based on erroneous facts, or for no reason at all, as long as its action is not for a discriminatory reason.'" Id. (citing Nix v. WLCY Radio/Rahall Communications, 738 F.2d 1181, 1187 (11th Cir.1984)). Often mistaken for more than what it is, most plaintiffs fail to comprehend that the anti-discrimination statutes are not federal civility codes. Mendoza v. Borden, Inc., 195 F.3d 1238, 1245 (11th Cir. 1999). Those laws simply do not extend to every action that makes an employee or former employee unhappy. Davis v. Town of Lake Park, 245 F.3d 1232, 1242 (11th Cir. 2001). Therefore, Dr. Adkins cannot prove discrimination by allegations of unfairness or showing he disagreed with the Defendants' interpretation of the hospital's rules. Dr. Adkins must show he was discriminated against because of his race by being suspended for similar or comparable conduct for which non-African-American physicians were not.

In Holifield v. Reno, the Eleventh Circuit addressed a case where an African-American physician sued the Bureau of Prisons after he was removed from his position at the Federal Correctional Institution in Marianna, Florida. Holifield v. Reno, 115 F.3d 1555 (11 th Cir. 1997). In its analysis of the plaintiff's claims, the

court noted that a "plaintiff must show that his employer treated similarly situated employees outside his classification more favorably than [him]self." Id. at 1562 (citation omitted). "To make a comparison of the plaintiff s treatment to that of non-minority employees, the plaintiff must show that he and the employees are similarly situated in all relevant respects." Id. (citations omitted). In determining whether employees are similarly situated for purposes of establishing a prima facie case, it is necessary to consider whether the employees are involved in or accused of the same or similar conduct and are disciplined in different ways. Id. (citations omitted).

The court compared the actions taken against the plaintiff to those taken against other physicians at the facility, "[r]ecognizing, however, that these are only a limited number of potential `similarly situated employees' when higher level supervisory positions for medical doctors are involved." Id. at 1563. The court distinguished the two comparators on the conduct complained of and found their conduct legally distinguishable. In response to the plaintiff's claim that other staff members "felt racism played a part in decisionmaking by the administration, and that not enough African-Americans were in positions of authority" at the facility, the court held that "the alleged biases of other staff members are not relevant. The biases of one who neither makes nor influences the challenged personnel decision are not probative in an employment discrimination case." Id. at 1563 (citations omitted).

In Anderson v. WBMG-42, the court held that comparators were similarly situated when they "fell

within the primary responsibility of one middle manager and the same supervisory chain of command." Anderson v. WBMG-42, 253 F.3d 561, 566 (11th Cir. 2001). However, the court rejected the defendants' broad assertion that "a plaintiff cannot prevail as a matter of law whenever two different supervisors are involved in disciplining the plaintiff and comparators." Id. The court noted that the involvement of two or more supervisors is simply one consideration for the court to make in determining whether a plaintiff was similarly situated to the comparators. Id.

The record clearly establishes that Dr. Adkins violated the various policies and procedures, written and unwritten, as alleged by the Defendants. There is absolutely no evidence whatsoever in the record that any of the Defendants applied the policies in a discriminatory manner. Dr. Adkins failed to identify a single similarly situated physician (surgeon, urologist or any other) who engaged in conduct comparable to that of Dr. Adkins, particularly considering the reprehensible conduct involving the surgery on the 7-month-old male patient. Dr. Adkins failed to show that the decisionmakers involved in his case knew about the alleged instances of misconduct by the other physicians. He failed to show that any of those individuals had their cases submitted to the same peer review panels or outside review boards. The record clearly shows that the hospital closely managed concerns with patient care, failure to timely complete medical records and any other ways in which a physician may violate the bylaws. For instance, one physician who had a case sent to peer review for various problems had a clearly distinguishable trait - the physician saw a problem during surgery and immediately ceased operating on

the patient, rather than proceeding with a surgery knowing there could be serious consequences. The same physician had a patient experience problems with severe blood loss but the blood loss was related to another individual prescribing the wrong medication. Another surgeon had a patient experience postoperative difficulties but the surgeon immediately responded to and remedied the problem. Two other physicians were disciplined for unprofessional conduct for responding to a hospital call after consuming alcoholic beverages. They were prohibited from serving in any elected office and from chairing any committees at the hospital. Another physician was fined for withholding information from a colleague's medical records. The evidence clearly establishes that the hospital applies its bylaws and standards of conduct to all physicians who violate the same without regard to a physician's race.

Dr. Adkins was unable to give clear examples of non-African-American doctors being treated more favorably under similar circumstances. His responses were: "I've known cases that were worse" and "I can't recall the names or whatever but I know for a fact."[4] His attempt as explaining that response was "I just know I have been treated differently, okay? That's the only thing I can tell you.... I can't get into specific dates and specific cases, but I've understood from staff in the hospital certain things.... I just know I'm treated differently. Okay? That's the best I can do."[5] The only specific examples he gave at that time was where another physician's patient had come into the emergency room because of a gunshot wound. Tragically, that patient died but Dr. Adkins failed to show how that particular doctor was treated more favorably in relation to any

peer review of the issue. Dr. Adkins also mentioned a case where another physician was accused of having sexual relations with one of his employees and abusing his prescription-writing privileges. The hospital suspended the physician, as did the Composite State Board, for 90 days. Dr. Adkins failed to point to any non-African-American physicians engaged in worse conduct than Dr. Adkins yet were not disciplined. Rumors, conclusory allegations and a plaintiff's subjective beliefs about the conduct of allegedly "similarly situated" individuals "are wholly insufficient evidence to establish a claim of discrimination as a matter of law." Mitchell v. Toledo Hosp., 964 F.2d 577 (6th Cir. 1992).

One of Dr. Adkins' primary disagreements with the Defendants is the issue of his availability, or lack thereof, to attend to the matter with the female patient. Dr. Adkins maintains that he adequately cared for the patient and "told people" he would be out of town but that they could contact him. The practice of the hospital was that the physician himself is ultimately responsible for notifying the Emergency Room if he is going to be out of town. Further, when a physician is called by the ER about one of his patients with an emergency condition, if that physician did not want to or was unable to care for the patient, the physician must let the ER know another physician is covering for him, and identify who that other physician will be. Further, when a physician admits a patient into the hospital, that physician is designating himself as the individual who will provide the primary care for the patient. If that physician is unable to care for the patient it is his responsibility to inform the hospital if there is someone different who will be taking care of the patient post

admission.[6] The record clearly shows that Dr. Adkins failed in every one of these responsibilities. He gave conflicting stories to his office and some individuals at the hospital regarding where he was going and when he was going out of town. Further, it was hours after the patient was readmitted to the hospital that Dr. Adkins finally arrived only to find that another physician had stepped in and taken care of Dr. Adkins' patient. Dr. Adkins cannot in light of the evidence before this Court deny that he failed in these responsibilities.

One important item of evidence is the list of physicians who in the last five years had their hospital privileges suspended at Houston Medical Center. That list shows the hospital evenly applies the rules to all physicians. The physicians who had been suspended were: 6 African American, 32 Caucasian and 9 Asian, all for various types of offenses. Of course, there is not an exactly equal number of physicians in those categories but the list is telling - the hospital has no problem disciplining physicians whose race is something other than African-American. The peer reviews of the physicians show the Hospital Authority takes substandard patient care, failure to attend to medical records and failure to be available for patients very seriously. If a physician violates the bylaws, or any other standard of care adopted by the various Departments, the Hospital Authority will take appropriate action against that physician by an informal file review by the Department Chair, a review by the MEC, PIC, an Ad Hoc Committee or a peer review Committee or a combination of all of the above.

Dr. Adkins failed to establish any of the Defendants violated his constitutional rights in the manner in which

he was disciplined and eventually suspended. Dr. Adkins failed to show that the Hospital Authority adopted, approved or in any way implemented policies, customs, practices or procedures that violated his constitutional rights. This is not a case where a genuine issue of material fact is created because of the subjective reasons given for the suspension of Dr. Adkins' privileges. Rather, the reasons given by the Defendants are based on written policies and procedures that the respective individual Defendants believed Dr. Adkins violated in a manner that placed patients at an increased risk of immediate and long-term harm. Dr. Adkins' only response to the Defendants' reasons for his suspension was that he believed what he did was sufficient in each case. Dr. Adkins does not dispute that the Defendants believed he used bad judgment, acted unprofessionally or violated the policies in question. Dr. Adkins simply responds that he does not feel that what he did showed bad judgment or unprofessional behavior or violated any hospital policies. This is not sufficient to defeat summary judgment in a case where the Defendants' opinion of Dr. Adkins' performance is the relevant issue. Although qualified immunity is determined under objective reasonableness standards, the individual Defendants' subjective intent is an essential element of the underlying allegation of a Constitutional violation. Defendants could not have violated Dr. Adkins' rights unless they had the intent to discriminate. Defendants suspended Dr. Adkins because they reasonably believed he violated hospital policies in a manner that jeopardized his patients' health and the efficient running of the hospital. These are lawful motivating factors. Because Dr. Adkins' suspension did not violate clearly established statutory or constitutional rights of

which a reasonable person would have known, the Defendants are entitled to qualified immunity from Dr. Adkins' § 1983 claims and to summary judgment in their favor.

Remaining Claims

Dr. Adkins claimed due process violations although it is unclear exactly how he is claiming his due process rights were violated. Any claim that Dr. Adkins is alleging is dismissed however because he failed to take advantage of the hearing process offered by the hospital and thoroughly explained to him in numerous letters from several different individuals. Faucher, 891 F.2d at 870871 (no due process claim where the plaintiff chose to address her grievances to a federal court rather than the hospital's appellate review procedures); Richards v. Emanuel County Hosp. Authority, 603 F. Supp. 81, 86 (S.D. Ga. 1984).

As to the § 1985 claim, Dr. Adkins claims the Defendants conspired to discriminate against him in the ways alleged above. The elements of a § 1985 conspiracy claim are "(1) a conspiracy; (2) for the purpose of depriving, directly or indirectly, any person or class of persons of the equal protection of the laws or of equal privileges and immunities under the laws; (3) an overt act in furtherance of the object of the conspiracy; and (4) that the plaintiff (a) was injured in his person or property, or (b) was deprived of having and exercising any right or privilege of a United States citizen." Byrd v. Clark, 783 F.2d 1002, 1007 (11th Cir. 1986) (citations omitted) (no longer good for one point of law not relevant to the case at bar). "The language of Section 1985 which requires an intent to deprive one of

equal protection or equal privileges and immunities means that there must be some racial or otherwise class-based invidiously discriminatory animus behind the conspirators' action." Id. at 1007-08. One of Dr. Adkins' examples of how the Defendants conspired against him is his allegation that Dr. Deighton was the driving force behind the female patient's complaint to the hospital and the JCHAO. That patient's deposition testimony clearly refutes this allegation. She stated that before she spoke to Dr. Deighton about her complaints regarding Dr. Adkins' care, during the time in which he was treating her after her final operation, she had already sent the initial complaint to the JCHAO. Further, Dr. Deighton did not disparage Dr. Adkins' care to the patient as alleged by Dr. Adkins. Rather, the patient testified that Dr. Deighton stated he was surprised to see an incision that large across her abdomen and that he would have done the procedure differently. When Dr. Adkins was asked in his deposition whether he felt any the other doctors were trying to take his patients, he responded, "I don't know." In fact, Dr. Adkins was never able to articulate a basis for suing any of the individual Defendants other than that he thought they were all involved in some way in the suspension of his privileges, even those who abstained from voting or who were never present for a particular committee meeting. Based on the findings related to the § 1981 claims, Dr. Adkins failed to establish a "conspiracy" for the purpose of depriving him, directly or indirectly, of the equal protection of the laws, failed to point to any overt acts in furtherance of the object of any alleged conspiracy or that he was deprived of having and exercising any right or privilege of a United States citizen. The §1985 claim is therefore dismissed.

Conclusion

Because the Court has dismissed all claims over which it has original jurisdiction, it declines to exercise supplemental jurisdiction over Dr. Adkins' state law claims, see 28 U.S.C. § 1367(c)(3), and those claims are dismissed without prejudice. Defendants' motions to dismiss and motions for summary judgment are GRANTED and judgment shall be entered in the Defendants' favor.

SO ORDERED this 2nd day of May, 2006.
S/
WILBUR D. OWENS, JR.
UNITED STATES DISTRICT JUDGE

Footnotes

[1] Art. XII, Sec. H, Par. 8.

[2] The patient stated that, during this visit, Dr. Adkins informed her he was going to Detroit the next day but Dr. Adkins denies he told her he was going out of town. The patient also testified that Dr. Adkins has since tried to convince her he never told her he was going to Detroit but the two could never agree on what was said. R. at 173, Ex. A., pp. 129, 267.

[3] Those documents will remain with the Court until 60 days after judgment is entered.

[4] plf.'s Dep. at 108.

[5] Id. at 110-114.

[6]R. at 159, p.197-198 (Depo. of Dr. Deighton, Chief of Staff). 18

No. 06-13107
UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

RUSSELL E. ADKINS, MD,
Plaintiff-Appellant,

Versus

ARTHUR P. CHRISTIE, Individually, and in his Official Capacity as the Administrator of Houston Medical Center, ANTHONY L. ALFORD, Individually and in his Official Capacity as Executive Director for Medical Affairs of Houston Medical Center, DANIEL A. DEIGHTON, Individually and in his Official Capacity as Chief of Staff and in his Official Capacity as a Member of the Medical Executive Committee at Houston Medical Center, FREDERICK W. JENNART, Individually and in his Official Capacity as a Member of the Medical Executive Committe at Houston Medical Center, DAVID N. HARVEY, MD, Individually, and in his Official Capacity as a Member of the Medical Executive Committee at Houston Medical Center, et al.,
Defendants-Appellees.

On Appeal from the United States District Court for the Middle District of Georgia

Aug 16 2007

ON PETITION(S) FOR REHEARING AND PETITION(S.) FOR REHEARTNG EN BANC

Before: EDMONDSON, Chief

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED,

ENTERED FOR THE COURT:

/s/CHARLES R. WILSON
UNITED STATES CIRCUIT JUDGE

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(4)

No. 07-538

FILED
NOV 20 2007
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The
Supreme Court of the United States

ARTHUR P. CHRISTIE, ANTHONY L. ALFORD, DANIEL E. DEIGHTON, FREDERICK W. JENNART, DAVID N. HARVEY, M.D., MICHAEL A. HELLWEGE, M.D., F. HUNT SANDERS, M.D., RICHARD J. SULLIVAN, M.D., TITUS A. TAUBE, M.D., C. SCOTT EDENFIELD, M.D., RAHIL KAZI, M.D., RICHARD L. HEATON, M.D., BRITTON L. PILCHER, M.D., SANTANU DAS, M.D., THOMAS C. JOHNSON, M.D., RICHARD B. ELLIS, M.D., HOSPITAL AUTHORITY OF HOUSTON COUNTY d/b/a/ HOUSTON MEDICAL CENTER,

Petitioners,

v.

RUSSELL E. ADKINS, M.D.,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether this Court should create a privilege against the disclosure of confidential medical peer review documents in the limited context of federal civil rights actions which allege discrimination within the peer review process, itself.

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STATEMENT OF FACTS AND COURSE OF PROCEEDINGS BELOW

The written opinion issued by the United States Court of Appeals for the Eleventh Circuit, published at *Christie, et al. v. Adkins,* 488 F.3d 1324 (11th Cir. 2007) and also located at Appendix (1a) of the Petition For Writ of Certiorari filed by the Petitioners held that the state-created medical peer review privilege shall not be recognized in a federal civil rights case alleging discrimination within the peer review process, itself.

The Eleventh Circuit Court of Appeals' opinion includes a comprehensive Statement of Facts And Course of Proceedings Below with which this Respondent agrees. To avoid redundancy herein, Respondent respectfully refers the Court to that opinion and shall not reiterate same herein.

INTRODUCTION

Petitioners present no "compelling reasons" for their Petition for a Writ of Certiorari to be granted. *See* Sup. Ct. R. 10. Specifically, Petitioners fail to demonstrate that the Eleventh Circuit's June 12, 2007 Opinion is in conflict with a decision of this Court or another Circuit Court of Appeals, or that the Eleventh Circuit has decided an important federal question which has not already been settled by this Court. *See* Sup. Ct. R. 10(a)-(c). Nor have they

demonstrated that there is a conflict among the decisions of this Court.

In fact, Petitioners fail to give more than cursory discussion of the fact that Congress has already "spoken" on this issue by expressly exempting civil rights cases from the Health Care Quality Improvement Act, which provides immunity for participants of peer review committees. *See* 42 U.S.C. §11111(a)(1).

Petitioners further fail to address the fact that although state laws *do* recognize a medical peer review privilege, many, if not all of the state laws create an exception to the privilege where there is bad faith participation within the peer review process itself.

As illustrated in more detail below, Petitioners have presented no viable reasons for this Court to review the question presented at this time, thus their Petition For Writ of Certiorari should be denied.

SUMMARY OF THE ARGUMENT

Petitioners contend that there is a conflict in two major decisions issued by this Court, to wit, *University of Pennsylvania v. EEOC,* 493 U.S. 182 (1990) and *Jaffee v. Redmond*, 518 U.S. 1 (1996) requiring resolution by this Court. This is incorrect. In *Univ. of Penn.* an important privilege was *not* recognized under federal law where the discrimination complained of occurred within the peer review

proceedings, themselves. 493 U.S. 182 (1990). Conversely, in *Jaffee,* plaintiff attempted to obtain psychiatric information about a police officer whom she was suing for a separate state wrongful death claim. 518 U.S. 1. The two cases are thus not in conflict, are distinguishable and present no reason for this Court's review.

Nor does the Eleventh Circuit's decision in the instant case conflict with *Jaffee*, as it is a limited holding and gives clear guidance to when the privilege will not be recognized.

Petitioners additionally strenuously argue that there is a split in the Circuits created by *United States v. Harris Methodist Ft. Worth,* 970 F.2d 94 (5th Cir. 1992) which requires resolution by this Court. However, that court specifically did not base its decision on the peer review privilege and rather decided the case based on the reasonableness of administrative searches under the Fourth Amendment. In fact, that court addressed the privilege only in passing and based its holding on other grounds. It thus has little, if anything, to do with the Court of Appeals decisions which *have* addressed this issue and which have *all* determined that the medical peer review privilege must yield to civil rights claims alleging discrimination within the process, itself. *See Virmani v. Novant Health, Inc.*, 259 F.3d 284 (4th Cir. 2001); *Memorial Hosp. For McHenry County v. Shadur*, 664 F.2d 1058 (7th Cir. 1981) and the instant

case, *Christie v. Adkins, et al.,* 488 F.3d 1324 (11th Cir. 2007).

Petitioners contend all states recognize a medical peer review privilege, thus this Court should acquiesce to the dictates of state law and likewise establish an air-tight privilege under federal law. This argument ignores the fact that even state medical peer review laws exempt from immunity those individuals acting in bad faith or with malice within the process, itself.

Petitioners also contend that due to the importance of confidential medical peer review proceedings, failing to recognize a privilege within the context of federal discrimination cases will eviscerate the public health benefits provided by medical peer review. While it cannot be disputed that medical peer review provides an important public purpose, it also cannot be denied that ferreting out invidious discrimination is likewise, if not a more compelling public policy issue. There are furthermore many quality of care and public health benefits to be derived from ensuring that competent minority physicians be protected from hindrance to their medical practices by those who are motivated by hatred and fear.

Further, an additional policy rationale for the confidentiality of medical peer review documentation is to protect it from being utilized by plaintiffs to prove standard of care issues in state medical malpractice actions. Failing to recognize the privilege in the limited context of federal discrimination claims

within the peer review process itself will not eviscerate such protections and those physicians acting in good faith within the process have nothing to fear.

REASONS FOR DENYING THE PETITION

I.

There Is No Conflict Between Decisions Rendered By This Court Requiring This Court To Hear This Case

Petitioners argue that because there is a conflict in two major decisions issued by this Court, to wit, *University of Pennsylvania v. EEOC,* 493 U.S. 182 (1990) and *Jaffee v. Redmond*, 518 U.S. 1 (1996), this Court should hear this matter in order to resolve same. However, a reading of the two decisions reveals that there is no true conflict.

Jaffee, 518 U.S. 1, 116 S.Ct. 1923, is simply not in conflict with this Court's ruling in *Univ. of Penn. v. EEOC*, 493 U.S. 182, nor with the Eleventh Circuit's ruling in the instant case. *See Appendix 1(a). Jaffee* involved a police officer who was being sued under state law for wrongful death due to her use of excessive force in fatally shooting an individual. 518 U.S. at 5, 116 S.Ct. 1923. The plaintiffs there sought notes from a psychotherapy counseling session that the police officer had participated in. *Id.* The psychotherapy sessions did not, however, form the basis of the underlying claim of excessive force. *Id.* There was thus a compelling reason to recognize the psychiatrist-patient privilege and the

Court found this privilege more important than assisting that plaintiff in proving her wrongful death case. This fact is a critical distinction.

In *Univ. of Penn*, 493 U.S. 182, 110 S.Ct. 577, on the other hand, a professor alleged she was denied tenure due to racial and sexual discrimination within the University peer review process. The University argued that the Court should recognize a peer review privilege within the University process which, it asserted, was "necessary to protect the integrity of the peer review process, which in turn is central to the proper functioning of many colleges and universities." *Id.* at 189.

This Court rejected that argument and expressly declined to extend the peer review privilege to that discrimination case, as it found that the costs associated with discrimination far outweighed the costs associated with the disclosure of peer review information. *Id.* at 193. Of particular import in that case was this Court's reasoning that because it was alleged that the discrimination actually occurred *within* the peer review process, itself, the discovery of same was especially relevant. *Id.*

The two cases thus do not create a conflict. Had they done so, this Court would have expressly overruled *Univ. of Penn.*, which it did not. This Court aptly noted that where discrimination occurs within the peer review process, itself, the privilege must fail. In *Jaffee,* however, where the reason for seeking privileged material does not occur within the privileged

process itself, the Courts must be guided by a laundry list of factors before recognizing an important privilege. 518 U.S. 1. This broader list takes into account whether a privilege generally "promotes sufficiently important interests to outweigh the need for probative evidence." 518 U.S. at 9-10.

Petitioners suggest that the Eleventh Circuit Court of Appeals' decision in the instant matter somehow conflicts with this Court's reasoning in *Jaffee*. 518 U.S. 1. Petitioners assert that *Jaffee* expressly rejected a "case by case" analysis to determine the recognition of a state privilege under federal law. The Eleventh Circuit did not, however, deviate from the rule enunciated in *Jaffee*. 518 U.S. 1. Its limited holding was simply that the peer review privilege would not apply in a federal case based upon discrimination within the peer review process, itself. *See Appendix 1(a)*. The Eleventh Circuit found, like in *Univ. of Penn.*, 493 U.S. 182, that eradicating discrimination was a more compelling reason to decline recognition of the peer review privilege than the need for confidentiality of documents. Thus, as required by *Jaffee*, the Eleventh Circuit provided a "forward looking test." 518 U.S. at 13. Every participant will know moving forward that the peer review privilege will not be recognized in a federal discrimination case.

The mischief sought to be avoided in *Jaffee* was the uncertainty created by a "case by case" analysis of whether to recognize a privilege under federal law. 518 U.S. 1. The Eleventh Circuit did not create a rule by which a case by case analysis will be conducted. It

merely held that in *all* cases of discrimination within the peer review process itself, the peer review privilege shall not be recognized. *See Appendix 1(a).* Nor did the Eleventh Circuit suggest the peer review privilege would *never* apply in another type of case, such as where a party seeks peer review documentation to support an underlying case which does not involve discrimination within the process itself, which was, in fact, the situation in *Jaffee.* 518 U.S. 1.

Likewise, as outlined in *Univ. of Penn.*, where discrimination occurs within the peer review process itself, and where the interests to be weighed are promoting healthcare or eradicating invidious discrimination, the interests in eradicating discrimination must prevail. 493 U.S. 182. Further, supporting minority physicians' ability to practice medicine in our countries' hospitals is a benefit worth promoting in order to assist in quality of healthcare to our citizens.

Because there is no conflict between the Eleventh Circuit's decision or this Court's cases, Petitioners have not presented a sufficient reason for this Court to hear this matter.

II.

There Does Not Exist A Split In Any Circuit Regarding This Issue Thus Resolution Is Not Required By This Court At This Time

Petitioners argue that there is a split in our nations' Circuit Courts which warrant this Court's

consideration. They base this "split" solely upon the decision in *United States v. Harris Methodist Ft. Worth*, 970 F.2d 94 (5th Cir. 1992). However, that case is not on point, creates no split in the Circuits and was premised on a different issue than the medical peer review privilege.

In *Harris*, the Department of Health and Human Services ("HHS"), a governmental agency, attempted to conduct a Title VI compliance review of a hospital chosen at random. 970 F.2d at 96. In attempting to conduct said review, HHS requested peer review materials on every physician at the hospital. *Id.* HHS argued that it was permitted to conduct an "administrative search" under Title VI of the Civil Rights Act as the hospital received federal funds. *Id.* It further argued that because the hospital had executed compliance assurance documents, it had consented to the administrative search. *Id.*

The Fifth Circuit Court of Appeals held that whether or not the administrative search could be conducted (and whether there was consent to same) was based on the objective reasonableness standard outlined by the Fourth Amendment. *Id.* at 100. Thus, only if the search was "reasonable" would it be permissible under Title VI. *Id.*

The Court found because the particular hospital was selected arbitrarily, without any guidelines and that the decision was made by a field officer with unreviewed discretion, that it was an unreasonable search under the Fourth Amendment. *Id.* at 101-02.

The Court thus declined to permit HHS to conduct the requested administrative search and found that any "consent" to the search did not trump the unreasonableness standard. *Id.*

The only portion of the *Harris* decision which dealt with the medical peer review privilege aspect of the case, expressly held that "HHS cannot administratively override the goal of Congress in enacting the Health Care Quality Improvement Act, 42 U.S.C. §§11101, 11137(b)." *Id.* at 103. The Court went on to hold that "because we affirm the district court's determination that the proposed search exceeded bounds of reasonableness, we need not define the scope of any applicable privilege." *Id.*

Thus, because *Harris* analyzed an administrative search under Title VI and under the Fourth Amendment, and because it expressly failed to reach a decision regarding the medical peer review privilege, it simply creates no split in any Circuit in the United States dealing with this issue. The court in *Harris* addressed the privilege only in passing and based its holding on other grounds. *Id.*

Contrarily, of all of the Circuit Courts of Appeals which *have* decided whether or not the medical peer review privilege is applicable in a civil rights action alleging discrimination (within the peer review process itself) the decisions are unanimous. Each Circuit reviewing this issue has found that the privilege must fail in these types of cases.

For example, in *Virmani v. Novant Health, Inc.*, 259 F.3d 284 (4th Cir. 2001) the Fourth Circuit indicated that "in contrast to a discrimination case, in which the plaintiff's claim arises out of the peer review proceedings, a plaintiff's claim in a medical malpractice case arises from actions that occurred independently of the review proceedings." The Fourth Circuit indicated that there is no evidence that state legislatures considered the potential impact on discrimination cases of a privilege for medical peer review proceedings. Thus, the state's policy decisions reflected different concerns than those implicated in a discrimination case. *Id.* This is particularly salient since discrimination claims pursuant to Title VII and 42 U.S.C. §1983 are peculiar to the federal arena and are not typically adjudicated in state courts.

Likewise, in *Memorial Hosp. for McHenry County v. Shadur*, 664 F.2d 1058 (7th Cir. 1981), the Seventh Circuit failed to recognize a medical peer review privilege in an antitrust action which alleged a physician was discriminated within the peer review process itself. The Court held that unlike in "the context of a medical malpractice claim [failing to recognize a privilege] will have little impact on the plaintiff's ability to prove a meritorious claim. For the crucial issue in that type of case is not what occurred at the review proceeding but whether the defendant was in fact negligent in his care and treatment of the plaintiff." *Id.* at 1061.

In the Eleventh Circuit below, the privilege was also denied on the same rationale utilized in *Univ. of*

Penn., 493 U.S. at 193 and the Fourth Circuit's analysis in *Virmani*, 259 F.3d at 289. *See Appendix 1(a).*

In fact, even before the instant case was decided, the district court in the Middle District of Georgia declined to recognize a medical peer review privilege in a discrimination claim requiring peer review documents to be turned over to a plaintiff-physician who alleged he had been discriminated against by the peer review committee. *See Marshall v. Americus-Sumter County Hosp. Authority,* 2002 U.S. Dist. LEXIS 26822 (S.D.G.A.).

It is thus clear that there are three (3) Circuit Courts of Appeals that have decided this issue, all of which declined to recognize the medical peer review privilege within the context of a discrimination claim arising from discrimination within the peer review process itself.

There is simply no split in the Circuits arising which makes the resolution of this matter ripe for this Court at this time.

Of further note is the fact that the majority of district courts have likewise ruled against recognition of the medical peer review privilege. *See, e.g., EEOC v. Franklin & Marshall Coll.*, 775 F.2d 110, 116 (3rd Cir. 1985) (peer review subject to discovery when discrimination alleged within the process); *Marshall v. Spectrum Med. Group,* 198 F.R.D. 1, 5 (D. Me. 2000) (declining to recognize privilege in discrimination suit brought pursuant to Americans with Disabilities Act); *Holland v. Muscatine Gen. Hosp.,* 971

F. Supp. 385, 390 (S.D. Iowa 1997) (declining to recognize privilege in Title VII claim); *Johnson v. Nyack Hosp.*, 169 F.R.D. 550, 561 (S.D.N.Y. 1996); *Robertson v. Neuromedical Ctr.*, 169 F.R.D. 80, 83-84 (M.D. La. 1996); *Lemasters v. Christ Hosp.*, 791 F. Supp. 188, 191 (S.D. Ohio 1991); *Wei v. Bodner*, 127 F.R.D. 91, 101 (D.N.J. 1989).

Some districts refer to the peer review privilege as the "self critical analysis privilege" or the "self analytical privilege" however it remains the same in substance. A majority of these district courts have likewise refused to honor it in discrimination cases such as the instant matter. *See, e.g., Johnson v. United Parcel Service, Inc.*, 220 F.R.D. 686 (M.D. Fla. 2002). Indeed, the U.S. District Court for the Southern District of Ohio indicated that

> while some cases discuss a "self-critical analysis" privilege, and others discuss a "peer review privilege" the two concepts stem from the same trunk. Some courts note a distinction between the two, others do not. The "self-critical analysis" is merely a way of describing, for example, a hospital's regular review, or evaluation, of its own in-house practices, and the work of its care-givers. It is, in other words, a more broadly focused, or generalized variant of peer review, which itself tends to be case-specific.

Nilvar v. Mercy Health Sys., 210 F.R.D. 597, 604, n.12 (S.D. Ohio 2002).

Regardless of the term utilized, the basic privilege and the analysis regarding its application to federal discrimination cases remains the same. *See, e.g., Bell v. Woodward Governor Co.*, 2004 U.S. Dist. LEXIS 1052 (N.D. Ill., Jan. 26, 2004), *Melendez v. Greiner*, 2003 U.S. Dist. LEXIS 19084 (2nd Cir. Oct. 22, 2003); *Johnson*, 220 F.R.D. 686 (M.D. Fla. 2002); *Leon v. County of San Diego*, 202 F.R.D. 631 (S.D. Cal. 2001); *Lizotte v. New York City Health And Hospitals Corp.*, 1989 U.S. Dist. LEXIS 14114 (S.D. N.Y. 1989); *Anderson v. Marion County Sheriff's Dept.*, 220 F.R.D. 555, 561 (S.D. Ind. 2004) (*holding* "the deliberative process privilege is unavailable where, as here, the plaintiff alleges discrimination under 42 U.S.C. §1983"); *Sonnino v. Univ. of Kansas Hosp. Auth.*, 220 F.R.D. 633, 644-645 (D. Kan. 2004) (*holding* "neither the Supreme Court nor the Tenth Circuit has recognized a medical peer review or medical risk management privilege under federal common law . . . nearly all of the cases that have weighed the state-law medical peer review privilege against the interests advanced by the federal anti-discrimination laws have concluded that the privilege does not preclude discovery of peer review materials").

In sum, cases emanating either from the district trial courts or the Circuit Courts of Appeals from the First, Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth, and now Eleventh Circuits have *all* declined to recognize a medical peer review privilege in the context of a federal discrimination claim.

This Court thus need not hear this matter at this time, as an overwhelming majority of district courts and all three (3) of the Circuit Courts of Appeals hearing the issue are not in conflict.

III.

Congress Has Already Addressed this Issue by Way of the Health Care Quality Improvement Act

In 1986 (as revised in 1989) Congress enacted the Health Care Quality Improvement Act ("HCQIA") in order to provide immunity from damages to individuals participating in professional review committees provided certain conditions are met. 42 U.S.C. §11111 *et seq.* An important exception to that act is relevant herein.

For example, the Act specifically exempts from its provisions "damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. §2000e, *et seq.* and the Civil Rights Acts, 42 U.S.C. §1981 *et seq.*" *See* 42 U.S.C. §11111(a)(1)(D).

It is thus clear that Congress specifically considered discrimination actions brought within the context of the peer review process itself and decided to expressly exempt them from the Act's purview. It is a basic rule of statutory construction that if something is expressly mentioned, the inference is stronger that those portions omitted were intended as such, than if

nothing at all was mentioned. *See* O.C.G.A. 50-21-20; *DHR v. Hutchinson,* 217 Ga. App. 70, 456 S.E.2d 642 (1995).

Although Petitioner argues that the HCQIA merely immunizes a peer review participant from damages, but does not speak to whether or not confidential documents are discoverable, this argument is displaced. For example, it has been held that the HCQIA did not apply, and could not be construed as limiting discovery of peer review documentation in civil rights cases. *See Lemasters v. Christ Hosp.,* 791 F.Supp. 188 (S.D. Ohio 1991); *Braswell v. Haywood Regional Medical Center,* 352 F. Supp.2d 639 (W.D.N.C. 2005); *Azeez P. Adeduntan v. Hosp. Auth. Of Clarke County,* 2005 WL 204248 (M.D.G.A.) (*holding* HCQIA does not bar peer review from disclosure in those cases where the peer review process itself is at issue.).

Petitioners argue that Representative Waxman (a sponsor of the House Bill) specifically addressed discovery of peer review documentation by stating, "I understand there are a number of State shield laws that restrict the type of evidence that may be introduced in lawsuits challenging a disciplinary action in the context of peer review. Nothing in this bill is intended to preempt or override any such State shield law." *See* 132 Cong. Rec. 33,177.

Although it cannot be determined that the necessary votes in both the House and the Senate agreed with such commentary, Representative Waxman was

expressly referring to the State shield laws which restrict discovery in malpractice actions against physicians and not the type of situation presented here. Had he been referring to same, there would not, of course, be a clear exemption for Civil Rights cases contained in the statute itself.

To that end, as Congress has already spoken on the issue, there is no need for this Court to review this claim unless and until Congress amends the Act.

IV.

State Peer Review Laws Create An Exception For Immunity Where Participants Act With Malice Or Bad Faith

Petitioners argue that effective (and confidential) medical peer review is essential to providing the public with quality healthcare. Certainly, it cannot be denied that peer review serves an important function in our society. It promotes effective supervision of healthcare professionals and treatment of those physicians in need of instruction or rehabilitation in terms of their practice performance.

However, medical peer review committees are a creation of statute and must be strictly construed and not extended beyond their spirit and "precisely stated limits." *McCall v. Henry Medical Center*, 250 Ga. App. 679, 551 S.E.2d 739 (2001).

Although virtually every state has enacted statutes providing for either immunity from lawsuits to peer review participants and/or confidentiality of the peer review documents, most of those same statutes provide an exception for participants who act with malice, fraud or bad faith within the process, itself. *See, e.g.,* O.C.G.A. §31-7-133 (Georgia); M.C.L. 331.531 (Michigan); LSA-R.S. 13.3715.3 (Louisiana) and similar statutes in Pennsylvania, Maryland, Texas, New York, New Jersey, Oklahoma, California, Missouri and Tennessee, to name a few.

It is thus apparent that even within the state peer review confidentiality statutes, it is recognized that actions taken with malice towards a physician will exempt the participant from immunity. Certainly, there can be no greater malicious act than invidious discrimination, whether it be based upon race, national origin or gender. This is especially so when minority physicians of all sorts have consistently assisted our healthcare systems in valuable ways.

In fact, it is a recognized fact that "sham" peer review processes have begun in our country where the confidentiality and privileges associated with peer review are utilized to rid hospitals of physicians for the hospitals' improper motives. *See* Hutton, Lawrence R., *Sham Peer Review: A National Epidemic,* Association of American Physicians and Surgeons, Inc. (2006).

Thus, Petitioner's argument that because all states recognize a peer review privilege under state law that this Court must likewise do so is simply not

a basis for this Court's review. As nearly all states have carved out an exception for malicious behavior within the process, itself, the Eleventh Circuit's opinion is thus in accordance with the states' policies.

V.

An Exception To The Peer Review Privilege Will Have No Substantial Effect On Those Participants Acting In Good Faith And Failing To Discriminate

Admittedly, it is important to the quality of health care to keep peer review documentation and discussions confidential. However, there is a distinction which Petitioners fail to address regarding the quality of care benefits derived from the existence of medical peer review, itself, and one of the compelling reasons for requiring actual peer review documents be completely *privileged* from disclosure. The distinction is between medical peer review and the medical peer review *privilege*.

Medical peer review committees themselves were created in order to provide peer-to-peer teaching mechanisms and to ferret out physicians who failed to meet proper standards of care. However, the confidential nature of said proceedings and privilege from disclosure of all documents/communications therein were created, in large part, to allow participants to speak candidly about another's performance *and* to prevent a potential state medical malpractice plaintiff from obtaining the documentation in order to prove a

breach of the standard of care. *See Eubanks v. Ferrier*, 245 Ga. 763, 267 S.E.2d 230 (1980). In that case it was held that denying a malpractice patient access to the records was not a violation of either due process or equal protection. *Id. See also Hollowell v. Jove*, 247 Ga. 678, 680, 279 S.E.2d 430, 432-33 (1981) ("[t]he statute legislatively approves the view that [c]onstructive criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit" *citing Bredice v. Doctor's Hospital, Inc.*, 50 F.R.D. 249, 250 (D.C. 1970).

Petitioners argue that by failing to recognize a medical peer review privilege in the limited context of civil rights claims alleging discrimination within the peer review process itself will "eviscerate" the public health benefits provided by such peer review. They argue that physicians will not participate in peer review if they know that their comments and/or documents are discoverable. In support of this argument they point to one small, rural county in western Georgia. Petitioners miss the point, however. If physicians do not act with discriminatory animus in the peer review proceedings, they have nothing to worry about. The exception carved out is a narrow one indeed and will not subject disclosure of documentation which can be used by the public to support malpractice actions to which the physicians must be concerned. All they need do is to refrain from discrimination.

As aptly noted in *Blaubergs v. Board of Regents of the University System of Georgia,* 661 F.2d 426 (5th Cir. Unit B 1981)

> Persons occupying positions of responsibility . . . often must make difficult decisions. The consequence of such responsibility is that occasionally the decision-maker will be called upon to explain his actions. In such a case, he must have the courage to stand up and publicly account for his decision. If that means that a few weak-willed individuals will be deterred from serving in positions of public trust, so be it; society is better off without their services. If the decisionmaker has acted for legitimate reasons, he has nothing to fear. We find nothing heroic or noble about the appellant's position, we see only an attempt to avoid responsibility for his actions.

Id. at 432.

Likewise here, so long as the decision-makers do not act with discriminatory animus, then they should not object if their decisions or discussions are questioned in a federal civil rights lawsuit. In fact, such documentation would most likely support their argument that no such discrimination occurred. To that end, physicians will not realistically be "chilled" from participating in medical peer review committees.

In fact, pursuant to Georgia Statutes, O.C.G.A. §37-5-1, the appointment of peer review groups and compliance therewith is required for the granting or renewing of a hospital's license. Thus, physicians will be required to continue to serve on committees, and like all public agencies, will be subject to anti-discrimination requirements.

Failing to exempt the privilege in federal discrimination cases will only have a chilling effect on "closed-door" discrimination sessions. If this occurs, it is certainly a chilling effect worth promoting and one that comports with over 40 years of federal jurisprudential efforts to eradicate invidious discrimination. *See* Title VII of the Civil Rights Act, 42 U.S.C. §2000(e) *et seq.*

Certainly, then, Petitioners' "parade of horribles" that the entire system of quality health care in our country will be chilled is not realistic and does not serve as a compelling reason for this Court to review this case.

CONCLUSION

For all of the foregoing reasons, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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No. 07-538

IN THE

Supreme Court of the United States

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Petitioners,

—v.—

RUSSELL E. ADKINS, M.D.,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

MOTION FOR LEAVE TO FILE AND BRIEF OF *AMICUS CURIAE* ASSOCIATION OF BLACK PHYSICIANS IN OPPOSITION TO CERTIORARI

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MOTION FOR LEAVE TO FILE AMICUS BRIEF IN OPPOSITION TO PETITION FOR CERTIORARI

Now comes the Association of Black Physicians and moves this Court for leave to file a brief as *amicus curiae.*

The Association of Black Physicians is a national organization of African-American physicians. As such, its members, on their own behalf, and on behalf of other physicians of color, are vitally concerned with the existence of viable remedies for institutionalized racism in the health care profession.

The Association of Black Physicians seeks to show that this Court's rejection of a federal privilege for academic peer review as contrary to congressional intent in enacting anti-discrimination law has equal application to hospital peer review. Lower federal courts have been virtually unanimous in denying recognition to a medical peer review privilege in the context of discrimination suits.

The Association of Black Physicians gave timely notice to the parties of its intent to file an amicus brief in this Court and sought the consent of the parties, which was withheld by Respondent..

Respectfully submitted,

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BRIEF IN OPPOSITION TO PETITION FOR CERTIORARI

QUESTION PRESENTED

Whether this Court should grant certiorari to revisit its holding in *Equal Employment Opportunity Commission* v. *University of Pennsylvania*, 433 U.S. 182 (1990), declining to recognize a peer review privilege under Rule 501 of the Federal Rules of Evidence.

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INTEREST OF AMICUS[1]

The Association of Black Physicians is a national organization of African-American physicians. Within the lifetime and memory of some members of the Association, African-American physicians were barred from practicing in "white" hospitals in some parts of the United States, and black patients were not permitted to utilize these hospitals. Its members, on their own behalf, and on behalf of other physicians of color, are vitally concerned with the existence of viable remedies for institutionalized racism in the health care profession, which may otherwise perpetuate through subtle means what was once done overtly.

Precisely because of the importance of the peer review process to the maintenance of high standards of medical practice, such peer review processes must be kept free of the extraneous influence of racial favoritism, avoiding less favorable treatment of African-American physicians and less accurate peer review.

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1 No counsel for a party authored this brief in whole or in part, and no person or entity other than *amicus* and its counsel made any monetary contribution toward the preparation and submission of this brief. Pursuant to Rule 37.2 (b), this brief is accompanied by a motion for leave to file as *amicus* after failing to receive the consent of all parties to its filing.

SUMMARY OF ARGUMENT

The reasoning of this Court in *University of Pennsylvania* v. *Equal Employment Opportunity Commission*, denying the creation of a federal privilege for peer review in the academic context has equal application to a hospital peer review privilege which would prevent discrimination suits from fully developing the evidence of disparate treatment on the basis of race or other protected categories.

Congress has chosen not to create such a privilege, both in its enactments of civil rights litigation after *University of Pennsylvania*, and in its enactment of the Health Care Quality Improvement Act.

The lower federal courts have been virtually unanimous in denying recognition to a medical peer review privilege in the context of discrimination suits.

There is thus no split among the circuits or important unresolved question to merit this Court's consideration.

PROCEDURAL HISTORY

Dr. Russell E. Adkins brought suit in the United States District Court for the Middle District of Georgia against the Houston Medical Center and numerous employees, under 42 U.S.C.§§ 1981, 1983, and 1985, asserting racial discrimination in his peer review evaluations, which were used to deprive him of privileges at the hospital. The District Court narrowed his discovery of peer review evaluations to the surgical department and a five year period, recognizing a medical peer review privilege and balancing his discovery against that privilege. Following discovery, the district court granted summary judgment to the defendants.

Dr. Adkins appealed, and the United States Court of Appeals for the Eleventh Circuit found that the district court had erred in recognizing a medical peer review privilege, and vacated the district court judgment on the ground that Dr. Adkins had been deprived of the discovery he was entitled to in order to prove his case.

After the Eleventh Circuit declined to rehear the appeal *en banc*, the Defendants petitioned this Court for certiorari.

ARGUMENT

A. Treatment of the Peer Review Privilege in this Court

In *Franklin and Marshall College* v. *Equal Employment Opportunity Commission,* 476 U.S. 1163 (1986), Justice White, joined by Justice Blackmun, dissented from the denial of certiorari, arguing that the holding of the Third Circuit Court of Appeals in that case, at 775 F. 2d 110 (1985), rejecting an asserted privilege for subpoenaed confidential peer reviewed materials, absent a showing of facts supporting an inference of discrimination, conflicted with the holding of the Seventh Circuit Court of Appeals in *EEOC* v. *University of Notre Dame du Lac,* 715 F. 2d 331 (1983).

However, four years later, in *University of Pennsylvania* v. *Equal Employment Opportunity Commission,* 433 U.S. 182 (1990), the United States Supreme Court took up the question, based upon the possible conflict between the Third Circuit's position and that of the Seventh Circuit, and unanimously rejected the recognition of federal peer review privilege in discrimination cases.

The Court's reasons for rejecting the privilege are at least as compelling today as they were at that time. This Court noted in *University of Pennsylvania,* that the creation of new privileges is to be avoided, since they are in derogation of the common law rule that the public has a right to every person's evidence. (citing *Trammel* v. *United States,* 445 U.S. 40, 50 (1980), and *United States* v. *Bryan,* 339 U.S. 323

(1950).

This Court noted, in *University of Pennsylvania*, that Congress, in enacting the Equal Employment Opportunities Act of 1972, had explicitly extended the reach of Title VII of the Civil Rights Act of 1964 to educational employees of universities, and had done so over arguments that this extension would hinder the universities' ability to hire and promote faculty members. 42 U.S.C.§ 2000e-(8) and 2000e-(9) provided the EEOC with the ability to gather evidence to investigate discrimination, using subpoena power if necessary. Congress had thus considered the competing concerns and had decided not to recognize the privilege, and the Court would not do so.

Moreover, the Court noted that however important the goal of permitting a university faculty to deliberate freely concerning the quality of peers being considered for tenure, this concern was outweighed by the "great, if not compelling" interest in eliminating invidious discrimination. *University of Pennsylvania, supra*, 433 U.S. at 193.

In the case at bar, the Petitioner seeks to have this Court revisit its holding in *University of Pennsylvania* v. *Equal Employment Opportunity Commission, supra,* 433 U.S. 182, in the context of peer review by a hospital. In enacting the Title VII of the Civil Rights Act of 1964, Congress made no distinction between hospitals and other employers covered by the statute. 42 U.S.C. § 2000e (a) and (b). While this case arises under separate statutes which prohibit racial discrimination in employment, particularly by a government entity and its employees, 42 U.S.C. §§ 1981, 1983 and 1985, it is inconceivable

that a rule of privilege which does not apply to racial and other discrimination claims under Title VII would be recognized under these statutes.

At the time this Court decided *University of Pennsylvania*, it noted: "Congress has made the choice. If it dislikes the result, it may revise the statute." 493 U.S. at 193. As discussed below, an examination of congressional enactments, far from changing the result of *University of Pennsylvania, supra,* with respect to hospitals, reinforces it.

B. Treatment of The Peer Review Privilege in Congress

Congress has declined many opportunities to take up the question of privilege in the context of federal discrimination suits, several of them in the immediate wake of the *University of Pennsylvania.*

For instance, later in the year that this Court announced *University of Pennsylvania,* Congress passed the Americans with Disabilities Act of 1990, 42 U.S.C.§ 12101 et seq., a comprehensive enactment involving discrimination in employment, public sector programs and services, and private sector services and facilities. In a legislative process which involved careful deliberation over provisions which were uncharted in their application to such a wide scope of possible discrimination, Congress did not see a need to add a peer review privilege.

In that same year, Congress amended the Age Discrimination in Employment Act, 29 U.S.C. § 621 et seq., with the Age Discrimination in Employment Claims Act of 1990. Again, Congress made no

amendment to have a peer review privilege included in the revised statute.

During the year following the determination by this Court of *University of Pennsylvania*, Congress passed 42 U.S.C.§ 1981a, the Civil Rights Restoration Act of 1991, and made no amendment adding a rule of peer review privilege in the context of race discrimination.

With respect to hospitals, even prior to *University of Pennsylvania*, Congress had enacted the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq. In enacting this statute, Congress chose not to extend any privilege to the peer review process in a healthcare setting. It is hardly credible that what Congress chose not to do in the context of a statute specifically addressed to healthcare deliberations by peer review bodies, it approved *sub silentio* in the context of the enforcement of civil rights against employment discrimination, a privilege which would impede the enforcement of these statutes promoting a "great, if not compelling" purpose. *University of Pennsylvania, supra*, 433 U.S.at 193.

Indeed, the importance of the peer review process to insuring the quality of medical care is further reason why Congress sought to insure that the process would not be poisoned by discriminatory practices which would make the process less reliable while adversely affecting physicians of color by introducing unfair negative factors into their evaluations.

C. The Peer Review Privilege in the Lower Courts

The lower federal courts have had no difficulty in discerning the rule enunciated by this Court, in *University of Pennsylvania* v. *Equal Employment Opportunity Commission,* rejecting the creation of a peer review privilege, nor in recognizing its application to the healthcare context, especially where civil rights violations are alleged.

Matter of Dinnan, 661 F. 2d 426 (5th Cir. 1981) anticipated the rule of *University of Pennsylvania*, in rejecting a claim of confidentiality of the peer review process where the plaintiff asserted that her denial of tenure had been based upon her gender.

Even at the time it was inclined to recognize a peer review privilege in an academic context, in *EEOC* v. *University of Notre Dame du Lac, supra*, 715 F. 2d 331, the Seventh Circuit declined to recognize such a privilege for a hospital peer group committee's disciplinary proceeding, despite recognizing a substantial state interest in correcting deficiencies in medical care, when the interest conflicted with the public interest in the ability of a private plaintiff to enforce federal antitrust law. *McHenry* v. *Shadur*, 664 F. 2d 1058 (1981). The Seventh Circuit was not addressing a civil rights claim. But there is an easy parallel in its recognized that, like the Plaintiff in the case at bar, the physician in that case would be frustrated in his ability to produce proofs, if he could not obtain discovery of disciplinary proceedings against other doctors which would show that other physicians with comparable or worse records were not denied staff privileges. (The same result was reached on similar reasoning by a district court faced with the same issue in an anti-trust suit, in *Robinson* v.

Magovern, 83 F.R.D. 79 (W.D. Pa. 1979).

The Fourth Circuit Court of Appeals, in *Virmani* v. *Novant Health Services*, 259 F. 3d 284 (2001), recognized that no medical peer review privilege should be recognized in the context of allegations of civil rights violations, following the reasoning of this Court in *University of Pennsylvania*, that the ferreting out of invidious discrimination was an interest that trumped the significant interest in candor in the peer review process.

Federal district courts, as well, have shown a virtual unanimity in refusing to recognize a peer review privilege for deliberations of a medical committee in the face of allegations of civil rights violations. Thus, the District Court in *Robertson* v. *Neuromedical Center*, 169 F.R.D. 80 (M.D. La. 1996), reasoned that Congress, in passing the Americans with Disabilities Act, had intended to pass sweeping legislation to protect persons with disabilities from discrimination, and that this outweighed the hospital's interest in the confidentiality of the peer review process. The court also relied on the Health Care Quality Improvement Act as indicating that Congress had not intended to afford the kind of records involved the degree of confidentiality which state law provided.

Johnson v. *Nyack Hospital*, 169 F.R.D. 550 (S.D.N.Y. 1996), in a race discrimination action under 42 U.S.C.§ 1981 and 1985, noted that Congress had specifically denied immunity under the Civil Rights Act for participants in peer review proceedings, showing that Congress accorded more weight to the vindication of civil rights than to the confidentiality of the peer review process..

The court in *Patt* v. *Family Health Systems,Inc.*, 189 F.R.D. 518 (E.D. Wisc.1999) was also persuaded that the legislative history of the Health Care Quality Improvement Act showed that Congress had considered and rejected a peer review privilege for medical review, and was willing to sacrifice the confidentiality of those proceedings to advance civil rights.

District courts faced with other civil rights claims have likewise eschewed recognition of a medical peer review privilege. In the employment context, the claim of a physician that he had been deprived of due process of law was found to compel disclosure of the peer review committee's communications which resulted in the denial to him of staff privileges. *Ott* v. *St. Luke Hospital of Campbell County, Inc.* 522 F. Supp. 706 (E.D. Ky. 1981).

In *Jenkins* v. *DeKalb County, Ga.*, 2007 WL 781870 (N.D. Ga. 2007), the district court considered the interest in vindication of civil rights of the decedent by the estate of an inmate which alleged that the inmate had been denied medical treatment and retaliated against by jail officials. The court declined to create a federal peer review privilege for the post-death investigation report.

Similarly, in *Marshall* v. *Spectrum Medical Group,* 198 F.R.D. 1 (D. Me. 2000), the court declined to recognize a federal peer review privilege to shield the plaintiff's credentialing file, where to do so might thwart his ability to prove disability discrimination.

Petitioners' attempt to portray the state of the law as one of "confusion" and "disarray" is simply inaccurate. As noted by Respondent, the Fifth Circuit,

in *United States* v. *Harris Methodist Ft. Worth*, 970 F.2d 94 (1992) did not address a medical peer review privilege in the context of a discrimination claim, but rejected as unreasonable an administrative search which sought documents of random targets pursuant to Title VI. This rule is consistent with the requirement of Title VII that a subpoena by the EEOC, to be enforceable, must be relevant to an investigation of discrimination. The recognition of a medical review privilege in discrimination cases is not necessary to the rejection of a roving commission without limits.

Hadix v. *Caruso*, 2006 LEXIS 72967 (W.D. Mich. Oct. 6, 2006), recognizes a medical peer review privilege in the context of prisoner's rights litigation, reasoning that such litigation over the quality of medical care is the constitutional equivalent of malpractice litigation. This decision is thus entirely capable of being harmonized with the rejection of such a privilege in the context of discrimination claims.

Petitioners are thus unable to point to a single instance in which a federal court has held a medical peer review privilege to prevent a discrimination plaintiff from obtaining discovery concerning the peer review process as applied to that plaintiff or as to others subject to peer review. This Court therefore has no occasion to address an issue which the lower federal courts have had no trouble understanding to be the logical extension of its ruling in *University of Pennsylvania* v. *Equal Employment Opportunity Commission*, and the manifest intent of Congress.

CONCLUSION

The history of the treatment of the peer review process in this Court, by Congress, and by the lower courts in discrimination cases demonstrates a clear understanding that federal courts should not recognize a peer review privilege, whether in the medical or academic setting, in the face of a suit alleging discrimination. There is therefore no important issue or split in the circuit courts requiring the attention of this Court.

Respectfully submitted,

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No. 07-538

IN THE

Supreme Court of the United States

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Petitioners,

v.

RUSSELL E. ADKINS,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURTS OF APPEAL FOR THE ELEVENTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF AMERICAN HOSPITAL ASSOCIATION, GEORGIA HOSPITAL ASSOCIATION, ALABAMA HOSPITAL ASSOCIATION, AND FLORIDA HOSPITAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF AMERICAN HOSPITAL ASSOCIATION, GEORGIA HOSPITAL ASSOCIATION, ALABAMA HOSPITAL ASSOCIATION, AND FLORIDA HOSPITAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Rule 37.2 of the Rules of this Court, the American Hospital Association, the Georgia Hospital Association, the Alabama Hospital Association, and the Florida Hospital Association (jointly "Associations") respectfully move for leave to file the attached brief as *amici curiae* in support of Petitioner. Counsel of Petitioners has consented to the filing of this brief, but counsel for Respondents has withheld consent. Accordingly, this motion for leave to file is necessary under Rule 37.2(b).

The Associations are non-profit state and/or national associations of hospitals and healthcare systems, devoted to improving the quality of healthcare in this country. The Eleventh Circuit's decision will directly and adversely affect members of each of these organizations because they reside in states located within the Eleventh Circuit.

The Associations fully support Petitioner's efforts to obtain review of the Question Presented in its petition. As more fully set forth in the accompanying brief, the Eleventh Circuit's decision was based on a misapplication of law and precedent and will establish horrendous healthcare policy that undercuts hospitals' efforts to assure the highest quality of patient care. By allowing access to peer review privileged materials through the vehicle of filing federal claims in federal court, the opinion will also increase litigation costs,

create incentives for forum shopping between state and federal courts, and encourage misuse of the discovery process throughout the Circuit. The Eleventh Circuit wrongly departed from the test set forth in this Court's decision in *Jaffee v. Redmond*, 518 U.S. 1 (1996), interpreting Federal Rule of Evidence 501.

For the foregoing reasons, the American Hospital Association, the Georgia Hospital Association, the Alabama Hospital Association, and the Florida Hospital Association respectfully request that they be allowed to participate in this case by filing the attached brief.

Respectfully submitted,

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INTEREST OF *AMICI CURIAE*

Amici curiae are the American Hospital Association, the Georgia Hospital Association, the Alabama Hospital Association, and the Florida Hospital Association.[1] The Associations are non-profit state and national associations of hospitals and healthcare systems. They each engage in advocacy and representation efforts to enhance their members' ability to serve the healthcare needs of patients within their geographical areas.

Each of the state associations represents hospitals that are directly affected by the Eleventh Circuit's decision because their members are in states that comprise the Eleventh Circuit. Most of these same members also belong to the American Hospital Association. These state associations, along with the American Hospital Association, recognize the serious harm that the Eleventh Circuit's decision will have on their hospital members' ability to safeguard the public health.

The *amici* support Petitioners' Petition for Writ of Certiorari because the Eleventh Circuit's decision is both bad law and horrendous public policy. Unless reversed by this Court, the Eleventh Circuit's decision will: (1) undermine efforts to protect and improve health care quality by hospitals and physicians, (2) conflict with this

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1. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae*, their members, or their counsel made a monetary contribution to its preparation or submission. Respondent has not consented to the filing of this brief.

Court's precedent and interpretation of Federal Rule of Evidence 501, which has set forth a specific test for federal recognition of common law privileges, and (3) increase litigation costs, disrupt quality review in hospitals, and encourage misuse of the discovery process in cases arising from physician staff privilege disputes by countenancing unfettered access to peer review privileged materials and deliberations.

SUMMARY OF ARGUMENT

As acknowledged by the Eleventh Circuit, all fifty states and the District of Columbia safeguard the confidentiality of information associated with medical staff peer review activities. In doing so, every state has recognized that in order to promote and enhance candid, frank and critical evaluation of medical professionals' skills and standard of care, there must be full and complete assurance that the peer review process will be protected from discovery in civil actions. Despite acknowledging the unanimous recognition of the peer review privilege by the states, the Eleventh Circuit nevertheless refused to uphold the privilege under Federal Rule of Evidence 501. Instead, it opened the peer review process to full-scale discovery, without any means of protection, if a federal claim is brought in federal court. If left standing, the Eleventh Circuit's opinion will seriously undercut hospitals' ability to ensure quality healthcare in Georgia, Florida, and Alabama.

The Eleventh Circuit's decision directly conflicts with this Court's recognition and application of federal common law privilege under Federal Rule of Evidence 501. In *Jaffee v. Redmond*, 518 U.S. 1, 12-13 (1996), this

Court explicitly observed that where, as here, states unanimously recognize a privilege, federal courts should also honor that privilege. Contrary to this Court's admonition in *Jaffee*, the Eleventh Circuit engaged in a balancing test, in which it decided that the interests in enforcing anti-discrimination laws outweigh the unanimous views of the states that peer review matters should be privileged. The Eleventh Circuit's opinion similarly conflicts with the Fifth Circuit's ruling in *United States v. Harris Methodist Fort Worth*, 970 F.2d 94, 103 (5th Cir. 1992), which recognized the status of the medical peer review privilege as a *sine qua non* of adequate healthcare.

From a policy perspective, the Eleventh Circuit's opinion will have additional adverse consequences. The decision will invariably increase litigation costs and impose onerous discovery burdens on hospitals in medical staff litigation. Physicians will be encouraged to convert routine staff privilege disputes into federal causes of action to gain access to federal courts, thus increasing the dockets of federal courts. As a result of the Eleventh Circuit's decision, the entire peer review process of the defendant hospital would be open to discovery – regardless of the relative merit of the underlying claim. The Eleventh Circuit's decision will have the perverse effect of encouraging plaintiffs to forum shop and file suits in federal courts to avoid being completely foreclosed from the medical peer review evidence as they would be in state courts.

Simply stated, the Eleventh Circuit's opinion is both bad law and bad public policy. This Court should grant certiorari and reverse the Eleventh Circuit.

ARGUMENT

A. Peer Review Confidentiality Is Critical To The American Health Care System

Every state in the nation protects confidential hospital peer review materials from discovery in litigation. At least 46 states have done so via legislation. *See Weekoty v. United States*, 30 F. Supp. 2d 1343, 1346 (D.N.M. 1998) (cataloging 46 states which have codified the medical peer review privilege).[2] Indeed, the Eleventh Circuit recognized this very fact in this case. *See Adkins v. Christie*, 488 F.3d 1324, 1327 (11th Cir. 2007).

Every state has protected peer review confidentiality as essential to state governmental efforts to promote and improve medical care quality. They understand the

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2. The states cited in the *Weekoty* decision excluded Massachusetts, South Carolina, Tennessee, and Utah as states legislatively recognizing the medical peer review privilege. Each of these states now has such a legislative enactment. *See* Mass. Gen. Laws ch. 111, § 204 (2007) (granting the privilege to proceedings, reports, and records of medical peer review committees, and exempting them from subpoena or discovery in judicial or administrative proceedings, with limited exceptions); S.C. Code Ann. § 40-47-190 (holding that all proceedings and information acquired by committees of medical staffs of hospitals acting pursuant to written bylaws are confidential and not subject to discovery, subpoena, or introduction into evidence); Tenn. Code Ann. § 63-6-219 (holding that all information furnished to or generated by peer review committees is privileged and not available for discovery or subpoena); Utah Code Ann. § 26-25-3 (holding information furnished to, among other things, peer review committees, or their findings or conclusions, are not subject to discovery, use, or receipt in evidence in any legal proceeding).

importance of confidentiality to encourage physicians to be candid and appropriately protective of patient care rendered by their peers on the medical staff. As described in Petitioner's brief, breach of peer review confidentiality will destroy a crucial safeguard in our healthcare system and will likely engender spurious staff privilege lawsuits that will unnecessarily burden our federal courts. *See* Pet. Br. at 6. Physician medical staff litigation will shift to federal courts based on federal claims of discrimination, antitrust conspiracies, or other federal claims, as plaintiffs seek access to internal professional self-criticisms that would be denied in state courts.

Numerous courts have refused to open the peer review process to discovery. For instance, the Supreme Court of Georgia noted that confidentiality is required "because of the concern that the candor necessary for the effective functioning of these [peer review] committees would be destroyed if their proceedings were discoverable." *Eubanks v. Ferrier*, 267 S.E.2d 230, 232 (Ga. 1980). Similarly, the Fifth Circuit distinguished the medical peer review privilege from academic peer review and like claims by writers, publishers, musicians, and lawyers, holding that "the medical peer review process 'is a *sine qua non* of adequate hospital care.'" *Harris Methodist*, 970 F.2d at 103. The District Court of New Mexico similarly held that if peer review sessions were open to discovery, physicians would not be as honest in their reviews, "and the goal of improving medical care would be substantially undermined." *Weekoty*, 30 F. Supp. 2d at 1346. The Eleventh Circuit's decision is completely contrary to the unanimous views of the states about the importance of protecting the peer review privilege and contrary to other federal courts.

B. The Eleventh Circuit's Opinion Contravenes The Supreme Court's Decision In *Jaffe v. Redmond*

In *Jaffee*, this Court stressed the importance of recognizing a privilege in federal court when states are unanimous in recognizing that same privilege. *Jaffee*, 518 U.S. at 12-13. *Jaffe* addressed the adoption of various aspects of the psychologist-patient privilege, noting that the "existence of a consensus among the States indicates that 'reason and experience' support recognition of the privilege," especially given that state legislatures, in creating privileges, take into account the importance of protecting the fact-finding capabilities of their courts. *Id.* at 13. Federal recognition of such privileges avoids "frustrat[ing] the purposes of the state legislation that was enacted to foster these confidential communications." *Id.* It also honors a privilege that is "'rooted in the imperative need for confidence and trust.'" *Id.* at 10.

Although the Eleventh Circuit below correctly observed that "all fifty states and the District of Columbia recognize [the medical peer review] privilege," *Adkins*, 488 F.3d at 1327, it attributed no significance to this fact. The Eleventh Circuit instead balanced two issues it deemed important: improved physician oversight and healthcare management, on the one hand, and the discovery of evidence of discrimination, on the other hand. *Id.* at 1328-29. This is the exact type of balancing analysis *Jaffee* explicitly rejected.

In *Jaffee*, the Seventh Circuit had recognized the psychotherapist-patient privilege, but concluded that a balancing test should be applied in each psychotherapist-patient case, weighing the privacy considerations against

the need for disclosure. *See Jaffee v. Redmond*, 51 F.3d 1346, 1357 (7th Cir. 1995). This Court rejected that approach because "participants in the confidential conversation 'must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.'" *Jaffee*, 518 U.S. at 18 (citing *Upjohn Co. v. United States*, 449 U.S. 383, 393 (1981)). Other commentators have criticized lower courts' failure to apply this precedent, noting that "[t]he *Virmani* court [*Virmani v. Novant Health Inc.*, 259 F.3d 284 (4th Cir. 2001)] . . . balanced the need for promoting candor among peer review members against the interests for evidence in medical malpractice and defamation claims . . ." instead of paying attention to the "reason and experience" of the states in creating the privilege. Teresa L. Salamon, *Note: When Revoking Privilege Leads to Invoking Privilege: Whether There is a Need to Recognize a Clearly Defined Medical Peer Review Privilege in Virmani v. Novant Health Inc.*, 47 Vill. L. Rev. 643, 667 (2002).

The analysis applied by the Eleventh Circuit in the present case bears the same flaws as the Seventh Circuit's approach in *Jaffee*, and is even more pernicious. Instead of making a case-by-case determination based on a given set of circumstances, the Eleventh Circuit decided that *any* physician complaint alleging discrimination is sufficient to revoke the privilege. Thus, whether a communication is privileged depends not on the circumstances under which the communication is made, but rather on conclusory allegations in a complaint alleging a violation of federal law. Consequently, doctors

and hospitals in the Eleventh Circuit will no longer have the certain knowledge that the confidentiality of their peer review actions will be protected in the future if they are sued in federal court under a civil rights, antitrust, or other type of federal claim. Instead, "[p]hysicians involved in peer review will need to forecast whether the subject of the peer review will sue in federal or state court to determine what degree of privilege might apply. The privilege becomes all but illusory and provides no notice to participants. . . ." *Id.* at 673; *see also* Alissa Marie Bassler, *Comment: Federal Law Should Keep Pace with States and Recognize a Medical Peer Review Privilege*, 39 Idaho L. Rev. 689, 711 (2003) (arguing that "[i]t is unreasonable to expect doctors to be able to feel isolated from liability if the privilege is only afforded in some situations"). Similar to the situation criticized by this Court in *Jaffee*, hospitals and doctors in essence will have no peer review privilege at all unless they are sued in state court.

Amici recognize that privileges created under Federal Rule of Evidence 501 may not be totally inviolate, but they should nevertheless be accorded appropriate respect and sensitivity. This Court in *Jaffee* addressed potential exceptions to the psychotherapist-patient privilege, contemplating that a breach of the psychotherapist-patient privilege would be warranted if necessary to avert serious threats of harm to the patient or a third party. *Jaffee*, 518 U.S. at 18 n.19. Likewise, federal courts (and state courts) employ a crime-fraud exception to the attorney-client privilege. These exceptions, however, are carefully and narrowly applied.

For example, this Court in *United States v. Zolin*, 491 U.S. 554 (1989), established a mechanism for determining whether the attorney-client privilege should be breached when the plaintiff alleged that legal representation was being used to plan a future crime or tort. This Court permitted *in camera* review of the privileged communications to determine first whether the privilege should apply. *See id.* at 568. Even before allowing this step, however, this Court insisted that plaintiffs seeking to breach the privilege must show "'a factual basis adequate to support a good faith belief by a reasonable person.'" *Id.* at 572 (citing *Caldwell v. Dist. Ct.*, 644 P.2d 26, 33 (Colo. 1982)). The Court's reason for applying this added showing was that "[t]here is no reason to permit opponents of the privilege to engage in groundless fishing expeditions, with the district courts as their unwitting (and perhaps unwilling) agents." *Id.* at 571. There were certainly numerous options available to the Eleventh Circuit in the present case which would have better served all interests, including *in camera* review of peer review materials, a more limited discovery order, or a requirement of something more than a conclusory allegation of discrimination before allowing unlimited discovery of the disputed materials. *See* Katherine T. Stukes, *Recent Development: The Medical Peer Review Privilege After Virmani*, 80 N.C. L. Rev. 1860, 1876-77 (2002) (noting that each of these alternatives should have been considered by the Fourth Circuit in the *Virmani* case).

Regrettably, the Eleventh Circuit's decision allows for just the sorts of "fishing expeditions" criticized by this Court in *Zolin*. Under the Eleventh Circuit's decision, if a physician plaintiff alleges some form of

federal claim in federal court, Federal Rule of Evidence 501 is ignored, and the peer review process is open to full discovery without limitation. The Eleventh Circuit's decision does not contemplate any preliminary *in camera* review, nor even any plausible factual basis test. It utterly fails to protect the medical review process from discovery abuse. Simply put, the Eleventh Circuit has frustrated the will of state legislatures in Georgia, Florida, and Alabama, and ignored the undisputed importance that confidentiality in the medical peer review process plays in safeguarding health care in hospitals.

C. The Circuits Are Split On The Issue Of Recognizing The Peer Review Privilege Under Federal Rule of Evidence 501

The Eleventh Circuit's opinion directly conflicts with the Fifth Circuit's opinion in *Harris Methodist*. The Fifth Circuit in that case weighed the interest of the Civil Rights Act in preventing employment discrimination against "the confidentiality of peer review, a process critical to the advancement of quality health care," and concluded that the peer review process trumped the need to prevent discrimination. *Harris Methodist*, 970 F.2d at 101. The Fifth Circuit recognized that protecting the inherent confidentiality of medical peer review materials serves an "important public interest," and that peer review "'is a *sine qua non* of adequate hospital care'" (unlike the rejected academic peer review privilege discussed in *University of Pa. v. E.E.O.C.*, 493 U.S. 182 (1990) that was not based on unanimous state recognition). *See id.* at 103 (citing *Bredice v. Doctors Hosp., Inc.*, 50 F.R.D. 249, 250 (D.D.C. 1970)). Although

the Fifth Circuit did not have to define the scope of the peer review privilege in that case because it found Fourth Amendment grounds to protect the documents, the Court of Appeals specifically affirmed the special and protected position of peer review documents.

There is a direct conflict in the Circuits over whether to uphold the state-sanctioned confidentiality of peer review proceedings. *Amici* acknowledge that two other Circuits – the Seventh and the Fourth – also refused to uphold the peer review privilege. *See Mem'l Hosp. v. Shadur*, 664 F.2d 1058 (7th Cir. 1981) (per curiam); *Virmani*, 259 F.3d at 284. The Seventh Circuit decision occurred prior to this Court's *Jaffee* decision, and the Fourth Circuit decision made the same erroneous balancing test that this Court specifically rejected in *Jaffee*. *See* Stukes, 80 N.C. L. Rev. at 1873. Furthermore, those decisions are in direct conflict with the Fifth Circuit's decision in *Harris*, which also preceded *Jaffee* and applied an inappropriate balancing test, but reached the correct result under *Jaffee*. Clarification of the correct application of F.R.E. 501 is urgently needed, and only this Court can provide this clarity.

D. The Eleventh Circuit's Opinion Will Lead To Discovery Abuse

As this Court recently recognized in *Bell Atl. Corp. v. Twombly*, 127 S. Ct. 1955 (2007), modern-day discovery is expensive and time consuming. This Court stated:

> [T]he threat of discovery expense will push cost-conscious defendants to settle even anemic cases before reaching those

> proceedings. Probably, then, it is only by taking care to require allegations that reach the level suggesting conspiracy that we can hope to avoid the potentially enormous expense of discovery in cases with no 'reasonably founded hope that the [discovery] process will reveal relevant evidence' to support a §1 claim.

Twombly, 127 S. Ct. at 1967 (quoting *Dura Pharms., Inc. v. Broudo*, 544 U.S. 336, 347 (2005)). Federal claims of discrimination, just like federal claims of antitrust conspiracies, lend themselves to conclusory allegations and very expensive and time-consuming discovery proceedings

The Eleventh Circuit's opinion, unless reversed by this Court, will have exactly the adverse effect this Court warned against in *Twombly*. In physician staff privilege claims brought in federal court, the Eleventh Circuit's ruling will have the dramatic effect of significantly raising the monetary and psychological costs of such cases by opening the hospital's peer review process across the entire medical staff simply through conclusory allegations of federal claims. By failing to recognize the significance of the peer review privilege under the *Jaffee* standards, the Eleventh Circuit's decision will encourage the misuse of the discovery process through "fishing expeditions" into a hospital's peer review files. The threat of such discovery will bludgeon hospitals and members of their medical staffs into settlements even in "anemic" cases. This is the very scenario that this Court correctly warned against and rejected in

Twombly. In fact, the district court in this very case observed such discovery misuse:

> It has become clear that plaintiff is not aware of any other similarly situated physicians at Houston Medical Center who engaged in similar or worse misconduct but were not disciplined or terminated. Rather, the plaintiff appears to be using the discovery process to determine if there may have been other physicians who fell into this category and if he *may* have been discriminatorily suspended. These are impermissible discovery objectives.

R5-103-3. Under a proper application of Federal Rule of Evidence 501 and *Twombly*, the Eleventh Circuit should have affirmed the District Court. Its failure to do so should not be countenanced by this Court.

E. The Eleventh Circuit's Decision Will Encourage Forum Shopping Between Federal And State Courts

The Eleventh Circuit's opinion will have the unfortunate effect of encouraging forum shopping. Plaintiff physicians will inevitably file medical staff claims in federal court, alleging antitrust or civil rights conspiracies as the basis for challenging peer review decisions, thus avoiding being completely foreclosed in state courts from discovery of medical peer review proceedings.

As this Court has held, forum shopping has long been disfavored because it "would be unfair for the character or result of a litigation materially to differ because the

suit had been brought in a federal court." *Hanna v. Plumer*, 380 U.S. 460, 467 (1965). Nonetheless, as a result of the Eleventh Circuit's opinion, identical conspiracy claims brought in federal court and state courts in Georgia, Alabama, and Florida are now going to involve very different discovery burdens and related costs on hospital-defendants because several years of the hospital's peer review process will now be open to discovery in federal courts. The Eleventh Circuit's opinion is also likely to result in artful pleading by physician plaintiffs, who "have an incentive to look for a federal question as a device for forcing disclosure in federal court." Bassler, 39 Idaho L. Rev. at 691 (arguing also that this division "takes away the very benefits created by state legislatures"). Such tactics will carry the very real threat of forcing suboptimal settlements by hospitals and medical staffs that strongly value the patient care benefits of peer review confidentiality. Hospitals and medical staffs may be forced to settle invalid claims rather than surrender the confidentiality of peer review records – all because a claim was brought in federal court instead of state court.

CONCLUSION

The Eleventh Circuit's decision should be reversed. If this Court's decisions in *Jaffee*, *Twombly*, and *Plumer* mean anything, the medical peer review privilege should be recognized and protected under Federal Rule of Evidence 501. If the privilege is not recognized, the Eleventh Circuit will have rendered a severe blow to protecting the safety and well-being of patients in hospitals throughout Georgia, Alabama, and Florida, and creating substantial economic burdens on hospitals to defend themselves in federal court. *Amici* respectfully urge this Court to grant petitioners' request for a writ of certiorari in this case.

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In The Supreme Court of the United States

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Petitioners,

v.

RUSSELL E. ADKINS, M.D.,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*; AND BRIEF *AMICUS CURIAE* OF THE JOINT COMMISSION IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Petitioners Arthur P. Christie, et al. ("Petitioners") have consented to the filing of this brief by *amicus curiae* The Joint Commission. Because the Respondent, Russell E. Adkins, M.D. ("Respondent"), has withheld consent, The Joint Commission hereby moves, pursuant to Supreme Court Rule 37.2(b), for leave to file an *amicus curiae* brief in support of Petitioners.

The Joint Commission is a private not-for-profit tax exempt 501(c)(3) corporation. It is governed by a 29-member Board of Commissioners that currently includes physicians, administrators, nurses, a labor leader, quality experts, an ethicist, a consumer patient safety advocate, and educators. The Board of Commissioners brings to The Joint Commission diverse experience in health care, business and public policy. The Joint Commission's corporate members are the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association. The Joint Commission is the nation's oldest and largest health care standards setting and accrediting body for health care organizations in this country.

The sole mission of The Joint Commission is to help enhance the quality and safety of health care through the provision of health care accreditation and

related services. In pursuit of this mission, The Joint Commission promulgates standards it believes health care organizations should meet to facilitate the provision of safe, high quality care, and surveys health care organizations for compliance with those standards. The Joint Commission accredits more than 14,000 health care organizations and programs in the United States, including hospitals and other health care organizations that provide home care, long term care, behavior health care, laboratory, and ambulatory care services.

Amicus participation is governed by Rule 37. Rule 37(1) states that "relevant matter not already brought to its attention by the parties may be of considerable help to the [Supreme] Court." As the nation's premier health care accrediting body, The Joint Commission is in a unique position to lend insight into the importance of the peer review process and the application of a privilege to that process in the health care setting. Because of its mission and the nature of its nationwide work, The Joint Commission has an interest in the application of the medical peer review privilege at the federal level and is directly affected by the Eleventh Circuit Court's decision.

The Joint Commission has repeatedly expressed its view that the confidentiality of peer review activity is critical if the safety of patient care is to be best protected and the quality of care is to be best enhanced. In this regard, any threat to consistency in the application of peer review statutes is of great

concern. The Joint Commission thus wishes to submit this brief to illustrate the impact of the Eleventh Circuit Court's decision on the health care industry. Given the ramifications of this case on The Joint Commission's work, it respectfully requests leave to file the attached brief *amicus curiae* in support of Petitioners' request that this Court hear this case.

Respectfully submitted,

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BRIEF OF THE JOINT COMMISSION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

This *amicus curiae* brief is submitted on behalf of The Joint Commission.[1] Petitioners have consented to The Joint Commission's filing of this brief. The Respondent has withheld consent. A motion for leave to file an *amicus curiae* brief under Supreme Court Rule 37(2)(b) is included with this brief. The correspondence regarding The Joint Commission's requests for consent have been filed in the Office of the Clerk.

I. INTEREST OF *AMICUS CURIAE*

The Joint Commission evaluates and accredits more than 14,000 health care organizations and programs in the United States. An independent, not-for-profit organization, The Joint Commission is the nation's predominant standards-setting and accrediting body in health care. Since its inception in 1951, The Joint Commission has maintained state-of-the-art standards that focus on improving the quality and safety of care provided by health care organizations. The Joint Commission's comprehensive accreditation process evaluates an organization's compliance with these standards and other accreditation requirements. Joint Commission accreditation is recognized

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[1] This brief was authored in whole by counsel for The Joint Commission. No person or entity made a monetary contribution to this brief's preparation or submission. *See,* Sup. Ct. R. 37.6.

nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Accreditation by The Joint Commission is of great importance to health care organizations. Among other reasons, the Medicare Act of 1965, 42 U.S.C. § 1395bb specifically provides that hospitals accredited by The Joint Commission, subject to certain limited exceptions, are deemed to be eligible to participate in the Medicare program. Thus, The Joint Commission plays a key role in the federal government's oversight of reimbursement for health care services. For one governmental purpose or another, the vast majority of states recognize Joint Commission accreditation.

Hospital medical staffs, pursuant to Joint Commission standards, participate in a "series of activities designed to collect, verify, and evaluate data relevant to a practitioner's professional performance." Hospital Accreditation Standards at 371, The Joint Commission on Accreditation of Healthcare Organizations (2007). The Joint Commission relies on these very peer review activities as the basis for accredited hospitals meeting appropriate medical staff standards.

II. SUMMARY OF ARGUMENT

The states have the responsibility to regulate health care with the purpose of protecting the quality and safety of care for patients in our nation's hospitals and health care organizations. One important method of accomplishing this is for states to enable physicians to be able to speak openly and candidly about health care rendered to patients, i.e., to be able to work together and, pursuant to medical staff bylaws, provide oversight for the quality of care, treatment, and services provided by health care practitioners. Hospital Accreditation Standards at 360, Joint Commission on Accreditation of Healthcare Organizations (2007). The peer review process and state laws that encourage peer review are intended to further this goal. The parties have addressed the peer review process, and certainly the federal courts have recognized the importance of peer review. It is the treatment of this process among state and federal courts, however, that causes The Joint Commission considerable concern, because there is a lack of consistency in how state and federal courts view the peer review privilege. The federal court interpretations can have the effect of thoroughly undermining a state's determinations about the peer review process intended to further the quality and safety of patient care in that state. In order to preserve the integrity of the peer review process, the impact of federal decisions cannot be isolated from the overall impact in that state.

Due to the unique position of The Joint Commission and its insistence in the pursuit of its mission that accredited organizations should engage in an effective peer review process, The Joint Commission respectfully requests this Court to accept *certiorari* in order to make clear to its lower federal courts the importance of this issue. Most notably, there presently exists a federal public policy against privileges that is based upon the underlying " . . . maxim that the public . . . has a right to every man's evidence." *Jaffee v. Redmond*, 518 U.S. 1, 9 (1996) (citations omitted). This policy is inconsistent with the purpose of peer review privileges established by state laws.

III. ARGUMENT

A. HEALTH CARE REGULATION, INCLUDING DETERMINING THE VALUE OF PEER REVIEW, IS LEFT TO THE STATES AS PART OF THEIR POLICE POWERS

Notwithstanding its position as a national organization that accredits health care institutions nationwide and its relationship with the federal government, The Joint Commission is fully aware that the actual regulation of health care is essentially left to the states. The Joint Commission understands that this role is generally considered to be a part of a state's police power to protect the health and welfare of citizens within each state. This Court, in fact, has recognized that states have " . . . great latitude under their police powers to legislate as to the protection of

the lives, limbs, health, comfort, and quiet of all persons." *Gonzalez v. Oregon*, 546 U.S. 243, 270 (2006) citing *Medronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996) (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 756 (1985)). What exists in federal jurisprudence has been a bedrock of state law. For example, in discussing Illinois' licensure act for physicians as prohibiting the practice of medicine without a license, that state's appellate court held such prohibition to be within "[t]he state's inherent police power . . . to enact reasonable legislation to secure the public's health and safety by licensing physicians." *People v. Ray*, 119 Ill.App.3d 180, 183, 456 N.E.2d 179, 182 (1983) citing *Rios v. Jones*, 63 Ill.2d 488, 348 N.E.2d 825 (1976). Further, Georgia's Supreme Court recognized that "[t]he preservation of public health is one of the duties devolving on the State as the sovereign power, and the discharge of this duty is accomplished by means of the exercise of the inherent police power of the sovereign." *Cobb County Kennestone Hosp. Authority v. Prince, et al.*, 242 Ga. 139, 143, 249 S.E.2d 584 (1978), citing *Hughes v. State Bd. of Med. Examiners*, 162 Ga. 246, 256, 134 S.E. 42, 46 (1926); *Yeargin v. Hamilton Mem'l Hosp.*, 225 Ga. 661, 171 S.E.2d 136 (1969). In furtherance of this police power, Georgia's state legislature promulgated the Hospital Authorities Law to provide for the "health and welfare of the community . . . [by] creat[ing] hospital authorities in order to promulgate rules and regulations 'necessary and convenient to carry out and effectuate' their purposes." *Id.*

at 144, 249 S.E.2d 584, 585, citing Ga. Code Ann. §§ 88-1801 et seq.

The states, of course, cannot effectively regulate health care without a system that incorporates professional expertise. Thus, peer review committees are formed "to evaluate the competence and quality of care rendered at medical institutions." Dorothy Duffy and Martha C. Romney, *Medicine and Law: Recent Developments in Peer Review and Informed Consent*, 26 Tort & Ins. L.J. 331 (1991). Medical peer review committees are essential to assess the competence of a medical staff and monitor a physician's performance. *Id.* To encourage participation and candor in that evaluation process, statutory privileges have been enacted to protect the work of all such committees. *Id.*

The peer review process as contained within state peer review statutes is a critical element of a state's regulation of health care. Numerous state courts have affirmed the importance of peer review, and have also affirmed that it remains within the ambit of state peer review protective statutes. In *Young v. Saldanha*, 189 W.Va. 330, 334 (1993), the West Virginia Supreme Court of Appeals recognized that "West Virginia's peer review statutes, like those enacted throughout the country [citing to, 3 Miles J. Zaremski & Louis S. Goldstein, Medical and Hospital Negligence, sec. 44A:07 n.1 (Callaghan 1991)] were put in force 'with the ultimate purpose of improving the quality of medical care in . . . this state.' *Daily Gazette Co. v. West Va. Bd. of Med.*, 177 W.Va. 316,

333, 352 S.E.2d 66, 71 (1986)." As examples of all states that have peer review statutes, the supreme courts of Illinois, Rhode Island, and Mississippi similarly recognize that the peer review process is to ensure and maintain quality of care. *Jenkins v. Wu*, 102 Ill.2d 468, 482 (1984) (confidentiality of peer review information " ... improve[s] health care within the State); *Moretti v. Lowe*, 592 A.2d 855, 857 (R.I. 1991) (discovery immunity is to be strictly construed and limited to its intended purposes; peer review is to ensure that medical care of high quality will be available to the public); and *Claypool v. Mladineo*, 724 So.2d 373, 385-386 (Miss. 1998) (agrees with *Moretti*, and finds peer review is to ensure that medical care of high quality will be available to the public, and the public purpose is not served if the privilege is applied beyond what was intended and necessary to accomplish the public purpose, and the purpose the language of the statute was intended to achieve).

The point The Joint Commission is respectfully making here is that peer review privileges cannot be viewed in isolation, but should be viewed as one critical piece in state regulation of health care.

B. CONFUSION REMAINS IN PEER REVIEW ANALYSES BY FEDERAL COURTS

Hospital engagement in peer review is one of the foundations of The Joint Commission's hospital

accreditation process. Uncertainty at the federal level in the application of peer review privilege protection will compromise the ability of peer review committees to adequately carry out their work. The Joint Commission's reliance upon peer review committees will be undermined, and the quality of care and patient safety will be adversely affected.

The appellate court in *Adkins v. Christie*, 488 F.3d 1324 (11th Cir. 2007) discussed the factors to consider in deciding whether or not a federal evidentiary privilege should be created. *Jaffee v. Redmond*, 518 U.S. 1, 10-16 (1996). The Joint Commission believes there is no question that what the states have done in enacting peer review privilege statutes serves the public good and fosters the imperative need for confidence and trust. By accepting *certiorari*, the Court would have the opportunity to make certain that quality of care and patient safety are not subservient to federal decisions discouraging privileges. In so doing, this Court also will have the opportunity to recognize that state law governing peer review as part of a state's responsibility to regulate health care should not be undermined at the federal level.

IV. CONCLUSION

The federal courts should not ignore the problem caused by a lack of consistency in the application of the peer review privilege. Accepting *certiorari* will allow this Court to set forth a solution to a problem in

an area that is vital to the quality of care and patient safety.

Respectfully submitted,

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IN THE

Supreme Court of the United States

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v.

Russell E. Adkins, M.D.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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REPLY BRIEF OF PETITIONERS

Respondent concedes that every state has recognized a medical peer review privilege. He also concedes that "admittedly, it is important to the quality of health care to keep peer review documentation and discussions confidential." Opp. at 19. Moreover, Respondent has no persuasive response to the inconsistencies between the Eleventh Circuit's analysis and this Court's decision in *Jaffee*, the tension between this Court's decisions in *University of Pennsylvania* and *Jaffee*, and the conflict between the Eleventh Circuit's decision and the Fifth Circuit's decision in *Harris Methodist Ft. Worth* concerning recognition of a medical peer review privilege.

Instead, Respondent sets up, and then knocks down, two straw men that are not actually implicated by this case. First, Respondent suggests that courts must choose between protecting medical peer review proceedings or allowing federal civil rights claims. That is not the case. Under the state law medical peer review privilege rules, discrimination plaintiffs continue to have access to a wide range of evidence, including depositions and requests for documentary evidence. The medical peer review privilege only shields one narrow category of evidence the disclosure of which would have important institutional ramifications for the overall quality of the health care system.

Second, Respondent suggests that because certain federal and state laws have declined to grant doctors *immunity* from lawsuits alleging discrimination, it follows that there can be no *privilege*

for medical peer review proceedings. Respondent is confusing two different concepts. Congress, in the Health Care Quality Improvement Act ("HCQIA"), along with certain states, has concluded that doctors should not be absolutely immunized from damages claims simply by virtue of the fact that they participate in peer review. But that does not speak to the evidentiary question of whether the records of peer review proceedings should be privileged because their disclosure would undermine the health care system. Congress simply did not speak to that question in the HCQIA, and states have overwhelmingly concluded that the importance of medical peer review to the health care system far outweighs the limited evidentiary value of this particular form of evidence. The Eleventh Circuit's decision severely undermines the judgment of states across the country.

1. As Respondent acknowledges, Opp. at 17, and as shown by the universal recognition of the medical peer review privilege by the states, the medical peer review privilege is critical to the quality of health care provided to the citizens of this country.

Medical peer review proceedings provide one of the few ways by which hospitals can discover and report doctors who pose a threat to their patients. However, the effectiveness of peer review proceedings depends upon the willingness of the participants to engage in candid discussions of the shortcomings of the treating physicians – physicians who often are colleagues of those participating in the review. Am. Hosp. Ass'n Br. at 4-5; Joint Comm'n Br. at 2.

As recognized by the states, the candor

necessary for effective peer review will suffer in the absence of a privilege. *See, e.g., Cruger v. Love*, 599 So. 2d 111, 114-15 (Fla. 1992) ("privilege afforded to peer review committees is intended to prohibit the chilling effect of the potential public disclosure of statements made to or information prepared for and used by the committee in carrying out its peer review function"). Indeed, medical peer review presents an even more compelling case for a privilege than does the psychotherapist-patient privilege protected in *Jaffee*, because the physicians who participate in a peer review are not acting in their self-interest. In the absence of a privilege, a patient still has a powerful incentive to provide sensitive information to her therapist: she will not receive effective psychotherapy without it. The physician who sits in judgment of his fellow doctor has no such self-interest, because the benefits of peer review flow entirely to others, *i.e.*, future patients and the public generally.

Like the psychotherapist-patient privilege recognized in *Jaffee*, the medical peer review privilege is "rooted in the imperative need for confidence and trust," promotes important "public ends," is recognized by every state in the country, and should be recognized under Federal Rule of Evidence 501. See *Jaffee v. Redmond*, 518 U.S. 1, 10, 13 (1996). The Eleventh Circuit's refusal to recognize the medical peer review privilege is contrary to *Jaffee* and should be reversed. It also is contrary to the reasoned judgment of every state that the importance of protecting the confidentiality of medical peer review communications necessitates recognition of a medical peer review privilege. *See, e.g., Sun Health Corp. v. Myers*, 70 P.3d 444, 447 (Ariz. Ct. App. 2003) ("The confidentiality of

peer review committee proceedings is essential to achieve complete investigation and review of medical care. Because review by one's peers within a hospital is not only time consuming, unpaid work, [and] likely to generate bad feelings and result in unpopularity, it is imperative to preserve the peer review privilege.") (internal citations and quotations omitted).

2. Respondent also offers no persuasive response to the tension between this Court's decisions in *University of Pennsylvania* and *Jaffee*. Contrary to Respondent's suggestion, *University of Pennsylvania* did not establish a bright line rule that peer review discovery is always allowed if the case in which peer review is sought involves an allegation of discrimination in the peer review process itself. Opp. at 6-7. As shown in Petitioners' petition, Pet. at 28-29, and further addressed below, such a rule is entirely inconsistent with the manner in which the states apply their peer review privilege laws.

The issue in *University of Pennsylvania* was "whether a *university* enjoys a special privilege, grounded in either the common law or the First Amendment, against disclosure of peer review materials that are relevant to charges of racial or sexual discrimination in *tenure decisions*." 493 U.S. 182, 184 (1990) (emphasis added). The medical peer review privilege is distinguishable from a peer review privilege in the academic context because a medical peer review privilege is recognized by every state and "is sine qua non of adequate hospital care." *United States v. Harris Methodist Ft. Worth*, 970 F.2d 94, 103 (5th Cir. 1992).

Respondent simply ignores the tension between *University of Pennsylvania* and *Jaffee*. Specifically, while *University of Pennsylvania* suggests a balancing test weighing the value of confidentiality against the need for disclosure in a particular case to determine whether to recognize a privilege, *Jaffee* expressly rejects such a balancing test. *Compare University of Pennsylvania*, 493 U.S. at 193 *with Jaffee*, 518 U.S. at 17. As *Jaffee* explained, such a balancing test eviscerates the effectiveness of a privilege: "[I]f the purpose of the privilege is to be served, the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all." 493 U.S. at 18 (internal quotations and citation omitted). And it is this tension between the *University of Pennsylvania* and *Jaffee* which has led to inconsistent results in the lower courts concerning recognition of the medical peer review privilege. Pet. at 24-25.

Moreover, Respondent ignores the fact that while the Fifth Circuit in *Harris Methodist Ft. Worth* declined to "define the scope" of any medical peer review privilege, it did, in fact, engage in the same comparison conducted by the Eleventh Circuit—the importance of rooting out discrimination against the importance of protecting medical peer review proceedings—and reached an entirely different result. *Compare Adkins v. Christie*, 488 F.3d 1324, 1328-29 (11th Cir. 2007) ("the privilege must be considered against a corresponding and overriding goal – the discovery of evidence essential in determining whether

there has been discrimination in employment") with *Harris Methodist Ft. Worth*, 970 F.2d at 103 ("important public interest" in the confidentiality of medical peer review is "overrid[ing]" goal supporting existence of privilege). *Harris Methodist Ft. Worth*, therefore, demonstrates a "conflict in approach" at least as strong as the split that prompted the Court to grant review in *University of Pennsylvania*.

3. Respondent suggests that courts must choose between protecting medical peer review proceedings or allowing federal civil rights claims. Opp. at 4. That is not the case.

Indeed, Respondent does not even address the numerous mechanisms outlined in Petitioners' petition as to how a plaintiff-physician could prove a discrimination claim, provided a viable one exists, without the confidential peer review materials. Pet. at 19. Along with the depositions outlined in Petitioners' petition, a physician-plaintiff also could seek similar documents from parties and non-parties. To be clear, the medical peer review privilege only shields one narrow category of evidence and that narrow category has important institutional ramifications for the overall quality of the health care system. *See, e.g., Patton v. St. Francis Hosp.*, 534 S.E.2d 526, 530 (Ga. App. 2000) (medical peer review privilege applies in suit challenging peer review process itself and privilege does "not deprive [plaintiff] of his right to access to the courts; [it] merely withhold[s] from him a certain type of evidence which would otherwise be available to him"); *Sun Health Corp.*, 70 P.3d at 449 ("A plaintiff has reasonable alternative ways to obtain the information without seeking privileged [peer review] information.").

4. Respondent, joined by amicus the Association of Black Physicians,[1] contends that because the HCQIA failed to grant doctors immunity from lawsuits alleging discrimination, that somehow Congress has declared that a peer review privilege should not be recognized. Opp. at 15; Ass'n of Black Physicians' Br. at 10. The HCQIA's text and legislative history shows this assertion is incorrect.

Congress simply did not speak to the question of recognition of a medical peer review privilege in the HCQIA. Specifically, in enacting the HCQIA, Congress was responding to concerns that "[t]he threat of private money damage liability under Federal laws, including treble damages under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review." 42 U.S.C. § 11101(4). Encouraging participation in peer review was important, Congress found, because of a "national need to restrict the ability of incompetent physicians to move from [s]tate to [s]tate without disclosure or discovery of the physician's previous damaging or incompetent performance." 42 U.S.C. § 11101(2). The Act, to encourage participation in effective medial peer review, assuages participants' concerns over liability by providing those involved in peer review with qualified civil immunity. See 42 U.S.C. § 11111.

Far from disapproving of an evidentiary privilege, Congress' enactment of the HCQIA complemented the peer review privilege. Congress' intent was for the HCQIA *not* to affect the states'

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[1] Petitioners consented to the Association of Black Physicians' request to file an amicus brief.

universal recognition of the privilege and corresponding application of the privilege in federal courts under Rule 501. Congressman Waxman, the main sponsor of the House bill, stated:

> The basic point to be made is that the courts should not read anything in this bill as authorizing the overriding of any State *and Federal law* relating to discovery. Specifically, I understand that there are a number of State shield laws that restrict the type of evidence that may be introduced in lawsuits challenging a disciplinary action in the context of peer review. Nothing in this bill is intended to preempt or override any such State shield law.

132 Cong. Rec. H11588-02 (emphasis added).

Yet that is what Respondent is arguing here, asserting the HCQIA, a statute that deals with immunity from damages, bars recognition of the evidentiary privilege under Rule 501. Respondent's argument was specifically rejected by the Fourth Circuit in *Virmani v. Novant Health Inc.*, a case upon which Respondent principally relies. 259 F.3d 284, 291 (4th Cir. 2001) ("we cannot conclude that Congress actually considered and rejected a privilege for medical review materials when enacting the HCQIA") (emphasis added). Moreover, in *Harris Methodist Ft. Worth*, the Fifth Circuit cited the HCQIA as, in fact, supporting recognition of the privilege. 970 F.2d at 103 ("As Congress has recognized, peer review materials are sensitive and inherently confidential, and protecting that confidentiality serves an important public interest. 42 U.S.C. §§ 11101(5), 11137(b)."). The Fifth Circuit's

analysis is consistent with the HCQIA's text and history, which demonstrate that the Act supports recognition of a medical peer review privilege under Rule 501.

Respondent also is wrong with respect to most of the states he contends have a malice/bad faith exception to a *privilege* from discovery of confidential, medical peer review communications. *See California Eye Institute v. Superior Court*, 215 Cal App 3d 1477 (Cal. App. 5th Dist. 1989) (providing "narrow exception" to peer review privilege for administrative mandamus actions and not for damages actions); *Freeman v. Piedmont Hosp.*, 444 S.E.2d 796, 798 (Ga. 1994) (no bad/faith malice exception for peer review discovery privilege); La. Rev. Stat. Ann. § 40:2205 (malice exception exists for immunity from liability, but not for *privilege* from discovery) Mich. Comp. Laws §§ 333.20175(8), 333.21515 (medical peer review discovery privilege); N.J. Stat. Ann. § 2A:84-22.8 (medical peer review discovery privilege); *Daly v. Genovese*, 466 N.Y.S.2d 428, 430 (App. Div., 2nd Dep't 1983) ("the allegation that the statements were made with malice, while relevant to a determination of whether they are privileged with respect to *liability*, is wholly irrelevant to the question of whether they are privileged from *discovery* under the terms of the statute"); Okla. Stat. tit. 63, § 1-1709 (medical peer review discovery privilege); Pa. Stat. Ann. tit. 63, § 425.4 (medical peer review discovery privilege); Tenn. Code Ann. § 63-6-219(e) (medical peer review discovery privilege).

As for the other states referred to by Respondent, they either allow limited peer review discovery but then impose absolute immunity from

liability to members of a peer review committee, Md. Code Ann. Health Occ. §§ 1-401(e), (f); allow peer review discovery when the peer review process itself is being challenged, Mo. Rev. Stat. § 537.035(5); or allow peer review discovery only if, after an *in camera* review, a trial judge makes a finding that the documents are relevant to an antitrust or civil rights claim, see *In re Ching*, 32 S.W.2d 306, 313 (Tex. Ct. App. 2000). Notably, *Jaffee* indicates that limited variations in the scope of the protections afforded by a privilege do not alter the "[s]tates' unanimous judgment that some form of [the] privilege is appropriate." 518 U.S. at 14 n.13.

Significantly, Georgia's appellate courts have specifically rejected the contentions made by Respondent here – that the medical peer review privilege should apply because the peer review process itself is at issue and because allegations of discrimination are involved. In fact, the Georgia Supreme Court explicitly held that interpreting Georgia's peer review privilege to include a malice/bad faith exception would:

> open the door of discovery too widely by stripping the entire peer review process of its confidentiality. . . . . Allowing an allegation of malice to trigger the applicability of [an] exception to the confidentiality requirement would result in the opportunity for full discovery of peer review material in every such case. The use of a bare allegation of malice is not sufficient to elevate a plaintiff's access to evidence over this court's previously stated preference for preserving the candor necessary for effective

peer review.

Freeman, 444 S.E.2d at 798 (emphasis added).

Similarly, the Georgia Court of Appeals has expressly rejected the argument that Georgia's peer review statute does not apply in cases challenging the peer review process itself: "To allow [such an] exception . . . would undermine the confidentiality afforded medical review committees and would swallow the rule. It is a rare case indeed in which disciplined physicians do not challenge the peer review process." *Patton*, 539 S.E.2d at 529-30 (internal citations omitted).

These opinions establish that, had Respondent filed this suit in state court, he would not be entitled to the peer review documents he seeks. Respondent's position, as accepted by the Eleventh Circuit, boils down to creating a rule that allows a plaintiff unfettered access to confidential peer review materials simply by baldy asserting discrimination or another federal claim.[2] While Respondent suggests Petitioners "miss the point" because physicians participating on peer review committees "have nothing to worry about"

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[2] In recognizing the medical peer review, the district court (1) conducted its own in camera reviews of the actual peer review documents, (R3-74-1; R3-80-2; R5-102-1; R7-169-1; R7-175-1); (2) asked repeatedly for Respondent to proffer any information he had to support his claims, which Respondent was unable to do, (R3-80-1-2; R5-103-12; R5-109-6; R7-169-1); (3) required the parties to submit discovery plans, which Respondent refused, (R1-82-2; R3-87-1; R4-96-1; R3-89-4); and (4) detailed for Respondent the manner in which he could prove his claims, but which Respondent elected not to pursue, (Pet. App. 20a).

if they "do not act with discriminatory animus in peer review proceedings,"[3] Opp. at 20, the Eleventh Circuit's rule means that all a plaintiff needs to do is allege discrimination to entirely eviscerate the privilege. Allowing a plaintiff unfettered access to each and every peer review file at a hospital simply by baldly asserting a discrimination claim invites the filing of meritless litigation against hospitals in the hope of coercing settlement, promotes forum shopping, abrogates each states' recognition of the medical peer review privilege, and puts at risk thousands of individual patients who rely each year on hospitals and their medical staffs for life-saving treatment and care.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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[3] Respondent has never made any showing of any discrimination perpetrated by any Petitioner. As Petitioners noted in their petition, the district court repeatedly warned Respondent throughout this action his Complaint appeared to be nothing more than a "fishing expedition." *Cf. Bell Atlantic Corp. v. Twombly*, 127 S. Ct. 1955, 1967 (2007).

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